Rocky Mountain Medical Journal

Title Registered, U. S. Patent Office

Publication Office
835 Republic Building, (1612 Tremont Place), Denver 2, Colorado
Telephone AComa 2-0547

Ownership and Sponsorship: The Rocky Mountain Medical Journal is owned by the Colorado State Medical Society and is published monthly as a nonprofit enterprise for the mutual benefit of the organizations which jointly sponsor it. It is published under the direction of the Board of Trustees of the Colorado State Medical Society, assisted by an Editorial Board representing the sponsoring organizations. It is the Official Journal of the Colorado State Medical Society, the Montana Medical Association, the New Mexico Medical Society, Utah State Medical Association, the Wyoming State Medical Society, the Rocky Mountain Medical Conference, and the Colorado Hospital Association.

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Advertising: National representatives: The State Medical Journal Advertising Bureau, Inc., 510 North Dearborn Street, Chicago 10, Ill. Local advertising from firms in the Rocky Mountain area should be submitted to the Associate Editor of the appropriate state or to the Journal office. Advertising forms close on the 15th of the month preceding publication; allow ten days additional to insure submitting proofs for approval.

Subscription: $3.50 per year in advance, postpaid in the United States and its possessions; single copy 35c plus postage. Subscription is included in medical society dues of sponsoring state medical organizations.

Second Class Matter: Entered as second class matter Jan. 22, 1906, at the Post Office at Denver, Colo., under the Act of Congress of March 3, 1879. Accepted for mailing at special rates of postage provided for in Section 1103, Act of Oct. 3, 1917; authorized July 17, 1918.

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VOLUME 53 JULY, 1956 NUMBER 7

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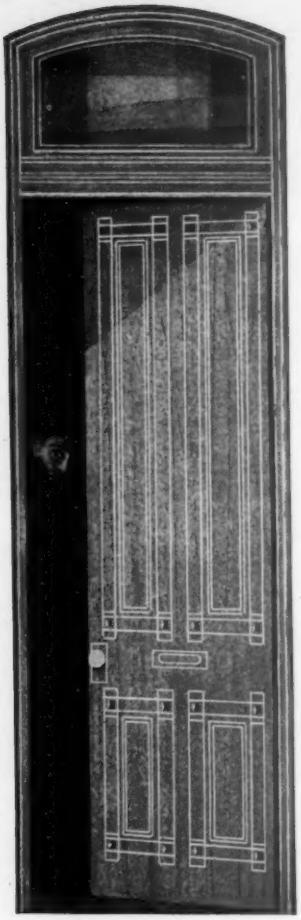

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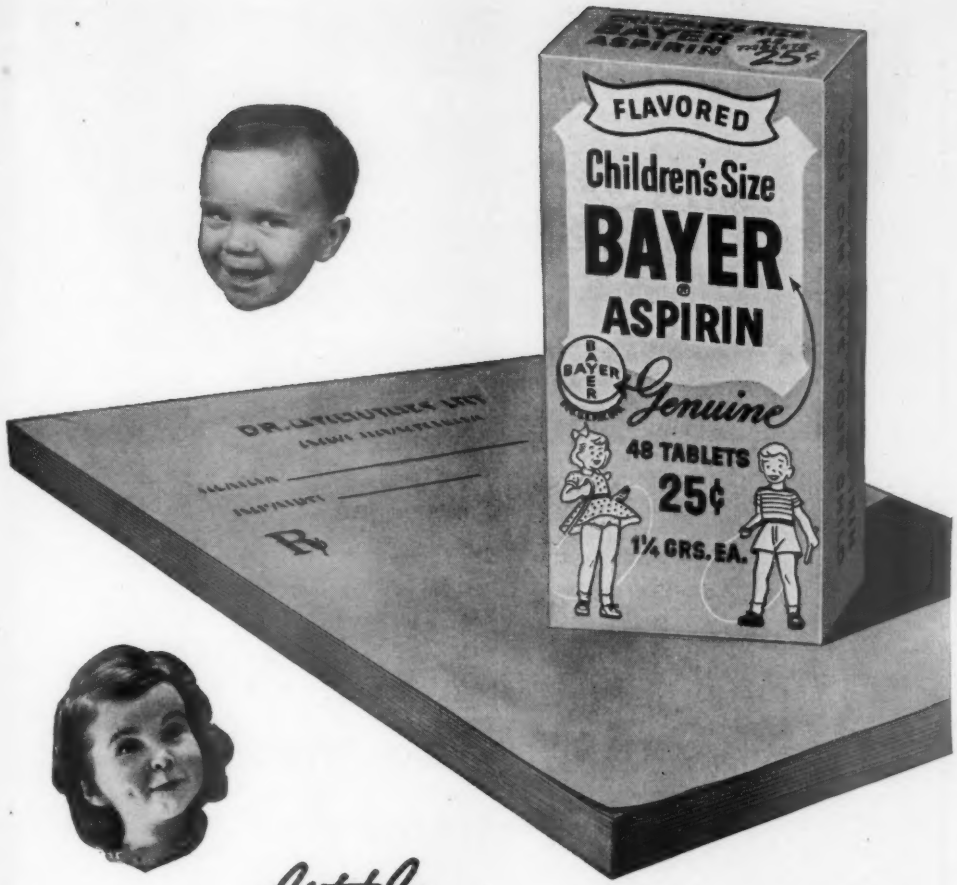

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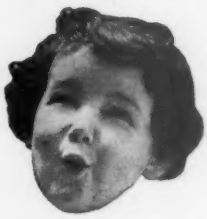

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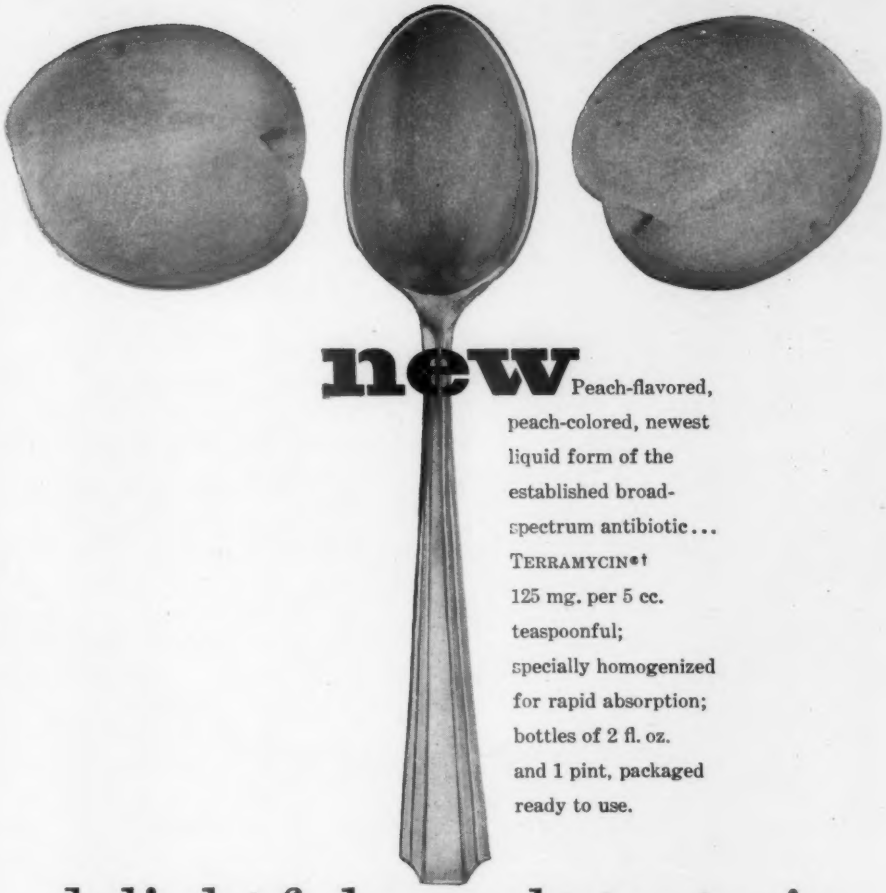

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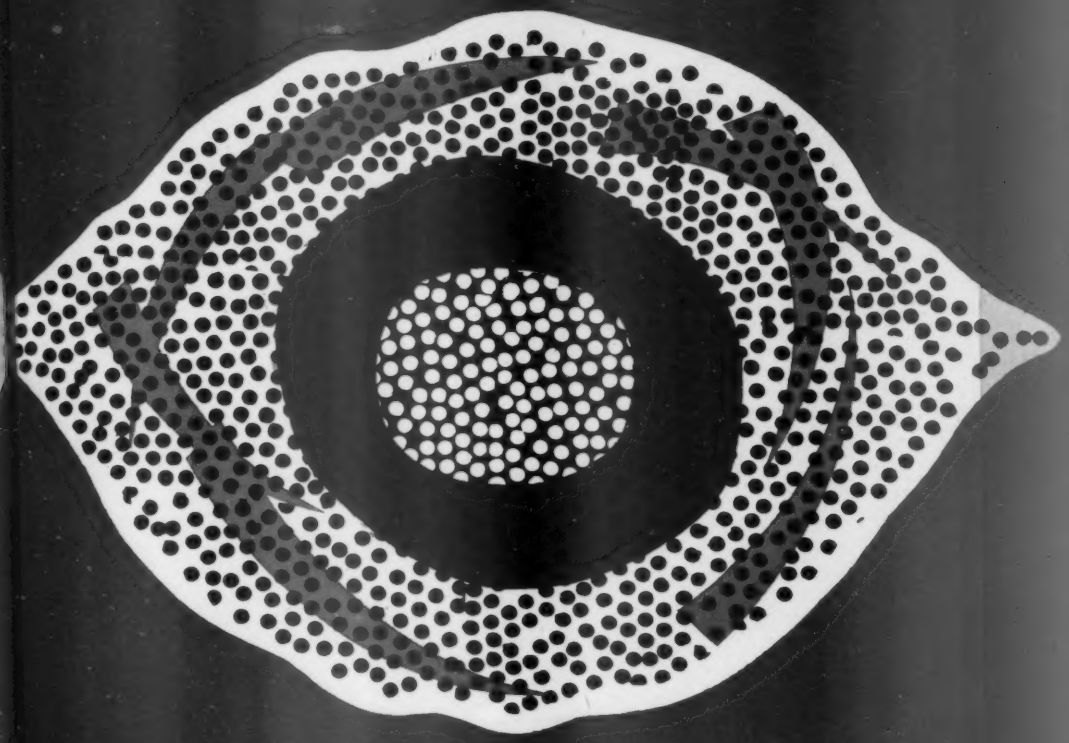

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EDITORIALS

Disability "Freeze" in the Social Security Law

IN RECENT months many physicians have heard from patients about the disability freeze provision in the social security law. This provision, added to the old-age and survivors insurance program in 1954, permits people who have prolonged total disability to apply to have their social security records frozen for the period of their disability. Thus, the time when they could not work and so had no earnings credited to their social security accounts does not count against them in determining their rights to benefits, nor the amount of benefits which will be payable to them at age 65, or to their families in case they should die.

Before a worker's social security record can be frozen, he has to meet certain work requirements. His social security record up to the time of his disability must show that he was in fact a worker, with a fairly regular and recent work history. In addition, he must be shown to have a medically determinable physical or mental impairment severe enough to keep him from engaging in any substantial gainful activity — one which has existed for more than six months, and is expected to last indefinitely or end in his death.

The medical evidence needed to establish the nature and severity of the applicant's disability, the date it began, and its prognosis comes from the doctor who has treated the worker and knows his case, or the hospital or institution in which the worker has been confined. A medical report form was designed to assist the physician in furnishing the needed medical evidence and to indicate the nature and extent of clinical detail which would be necessary. It is given to the applicant for the "disability freeze" and he is asked to have it filled out by the physician most familiar with his impairment. The form itself is modeled closely after the medical report used by major life insurance companies in their disability claims work. In adapting it for use in the "freeze" program, the recommendations of a Medical Advisory Committee were closely followed. This committee, composed of well qualified representatives of the medical and related nonmedical professions, gives advice and guidance to the Social Security Administration on the medical aspects of the "disability freeze" program.

If you have received this medical form to fill out for any of your patients, you are probably aware that the law makes the disabled worker responsible for seeing that medical evidence is submitted for paying any costs involved and for him. The law does not permit the Government to pay any costs in connection with securing the medical evidence needed for a determination of disability. You may also know that to insure the confidentiality of the medical evidence, the medical report form is not to be returned to the patient, but is to be mailed by the physician direct to the local social security office.

Determinations as to disability based on the evidence submitted are made under an agreement with the Federal Government by professional members of an agency of the state in which the applicant resides. In most states this is the vocational rehabilitation agency. Since referral of disabled individuals for any rehabilitative services which might return them to gainful work is an important aspect of the program, each person applying for the social security disability freeze is told about the availability of vocational rehabilitation services.

On the professional team in the state agency at least one member is a doctor of medicine. The team reviews and evaluates all medical evidence assembled in the applicant's file, as well as such non-medical factors as age, education and occupational ex-

perience. Certain medical guides and standards, worked out with the advice of the Medical Advisory Committee, are used in the consideration of the medical evidence. But, although these guides and standards can be applied in most cases, they are not rigid and arbitrary. The final determination in each case is based on all the available facts on the individual's impairment and vocational history, and there is consultation among physicians in any borderline situation.

No matter how good the standards, nor how considered the judgment of the reviewing team, the determination reached can be no sounder than the evidence upon which it is based. To make sure that he is providing sufficient medical evidence for a prompt and fair determination, the doctor will want to consider the following guides in filling out medical report forms for those of his patients who have applied for the social security disability freeze:

1. Include sufficient clinical detail to enable the reviewing team to make a sound determination as to the severity and extent of the patient's current condition.

2. Give enough of the clinical history to provide information as to when the disability began, and when it became so severe as to keep the patient from working.

3. Describe the probable course of the condition from now on, so that a decision can be reached as to whether the impairment is likely to continue indefinitely, or end in death, or whether it is self-limiting, or remediable in the forseeable future.

Prognosis in Viral Hepatitis

DURING the summer of 1951 these columns presented an editorial upon the subject of viral hepatitis, which at that time afflicted many members of our profession and its ancillary workers. The editorial was perhaps the most authoritative that these columns have presented in years, for its author, yellow as a pumpkin, was propped up in bed reviewing some twenty-three functions of the liver as described in a pile of old textbooks. At least twenty-one of those functions, he was sure, were extinct, and the author fully expected to see little else of his dwindling world—and what of it remained for him—only through two jaundiced eyes. But recovery occurred, and liver function tests were given up as rehabilitation became mandatory for many reasons, liver or no liver. Only occasionally has the author of that missive speculated as to what degree cirrhosis may have replaced the parenchyma of that ponderous and all important organ.

It is gratifying to note that the almost epidemic number of cases has subsided and time has proved that ultimate prognosis is good, despite immediate high mortality rates, particularly in military cases. Sinclair, in the Proceedings of the 42nd Annual Meeting of the Medical Section of the American Life Convention, reviewed the hepatitis story up to that time. Apparently not over 0.6 per cent of cases of hepatitis with jaundice gave rise to chronic disease. Proved cirrhosis resulting from viral hepatitis is rare, if it exists at all. Functional and structural abnormalities of the liver do not seem to exist in people who have had viral hepatitis. We know that both symptomatic and some asymptomatic patients became carriers who might transmit the disease, especially as blood donors, without having any personal health problems. Standard insurance rates have been granted to some of these people, except in cases particularly prolonged or recurrent; even in these instances, standard rates may be granted after three years of penalty rates.

Imbibed toxic substances, notoriously alcohol, sometimes result in cirrhosis. However, those who are reluctant to entertain anything but friendly feelings toward alcohol would keep the question controversial. Who can prove that the liver damage in so-called alcoholic cirrhosis does not represent a deficiency disease? Likewise, in cases of hepatitis, liver damage could be due to causes other than the virus.

Many of us, particularly those who have had the disease, are pleased to abandon the question at the controversial level. We are delighted that, statistically, complete recovery apparently occurs!

Headache*

Samuel Werner, M.D.
BILLINGS, MONTANA

INASMUCH as most of the studies on headache have emanated in the field of neurology, this subject will be presented chiefly from a neurological point of view. At the onset, we must ask ourselves a very simple question, "What is there in and around the head of a human being that can hurt?" In other words, "Which structures are pain sensitive and which are not?" For the purpose of discussion, the head may be divided, anatomically, into four divisions. These are: Intracranial, the extracranial, the nuchal, or cervical, and the precranial. The precranial division refers to the face and structures underlying it. Many of the pioneer neurosurgeons were amazed to find that the brain itself is insensitive to pain. The development of the neurological surgery to its present level of efficiency and margin of safety has permitted the physiologist to study the exposed intracranial contents and to come up with rather definite data. Dr. Harold Wolf, of Cornell University, is recognized as the undisputed leader in the field of neurophysiologic research and Dr. T. C. J. VonStorch and his associate, Dr. Arnold Friedman of new York, were among the early Americans who pioneered in this field.

Now, what intracranial structures can produce pain? The parenchyma of the brain, the ependyma of the ventricles, the choroid plexus, most of the dura and the pia mater, including the diploe and emissary veins in the skull, are all insensitive to pain. This leaves six basic mechanisms. First is traction and displacement of the great venous sinuses and of the great veins as they enter the venous sinuses. Second is traction on the middle meningeal arteries. Third is traction on the great arteries at the base of the skull, those in the circle of Willis and the proximal end of the branches going away from the circle. The next is distention, or dilatation, of these intracranial arteries, venous sinuses and big veins. If you should pull on these structures, or blow them up, pain will ensue. Then, too, the basic neural mechanism can be involved, such as direct pressure or traction, by a tumor, on the pain nerve endings of the nerves which innervate the meninges. These are the fifth nerve in the supratentorial region, the ninth, and upper cervical, nerves in the subtentorial region. The last is inflammation of these structures; that is, inflammation of the great vessels especially at the base, and inflammation of the nerve endings. One can, therefore, see that the pain producing mechanism in the head does not differ very much from those in the viscera. For example, take the gallbladder. You can squeeze it, pinch it or stick it with a pin and no pain will ensue, but if you should dilate it, pull it or inflame it, pain will take place.

Now, what are the extracrannial structures which are capable of producing pain? They are, very simply, the blood vessels, the soft tissues and the periosteum of the skull. Of these, the blood vessels are, by far, more capable of producing pain than any other structure. Pain in these blood vessels, especially the arteries of the scalp, can produce pain by dilatation or traction. Pain is invoked in the soft tissues of the head and the periosteum by inflammation.

Now, for a moment, let us turn to the precranial, or facial, mechanisms that produce pain. You might be surprised to hear that a faradic stimulation of the wall of the nose, and paranasal sinuses, will cause an extremely low degree of pain. If you bal-

*Presented at the meeting of the medical staff of the Deaconess Hospital, Billings, September 26, 1955.

loon up the sinuses with a high degree of pressure, or if you should produce a negative pressure in one of the paranasal sinuses, a very low order of pain will ensue. However, this is not true of the ostea of the sinuses. There, upon any kind of stimulation, whether it is electrical, pressure or distention, a great deal of pain will be produced and the same is quite true of the nasal lacrimal duct, and of the turbinates. Therefore, most of the pain in the nose and paranasal sinuses arises in the ostea of the sinuses, and in the turbinates.

Let us now turn to the eye. If one should pinch, stick or cut an intraocular muscle, pain will not be produced. However, this is not true of traction. If one should pull on the extraocular muscles, a great deal of pain, that is, a deep orbital pain, will spread over the ophthalmic division of the fifth nerve across the midline, and produce frontal headache. Increased intraocular pressure will produce retro-orbital pain which, if it lasts long enough, will spread over to the whole ophthalmic division and produce frontal pain. Eye surgeons can tell you from their experience in the performance of iridectomies and anterior chamber surgery, that pulling on the iris and the uveal tract will produce the same kind of deep retro-orbital pain which can then spread frontally. Therefore, in glaucoma, hyperopia, astigmatism and other muscular imbalances; due to the pull on the extraocular muscles, deep retro-orbital pain will ensue.

We now come to the muscles of the head and neck as a source of pain. By this is meant primarily the posterior occipital muscles and, to a lesser extent, the temporalis muscles. When these muscles are in a state of spasm, pain is produced.

There is another rare cause for the mechanism of pain in and around the head. This is a phenomena of central excitation and overflow. Impulses going up over the mandibular or maxillary division of the fifth nerve may proceed centrally to the level of the thalamus and cause a spread phenomena, resulting in generalized headache. For example, the so-called "ice cream headache," and I am sure a good many of you members have experienced this same type of headache in the past. Some people contend that pain in the teeth and the alveolar ridges can also cause central excitation, with spread, so that generalized headache results as an overflow phenomena.

I should now like to run, briefly, through the clinical syndromes of headache in the order of their frequency. First, tension headache. Psychoneurotic headache, psychosomatic headache, or whatever name one wishes to call it, is the most common type of headache that most physicians see. This is primarily a nuchal headache, certainly in the beginning. The mechanism for the so-called tension headache, or psychogenic headache, is tension in the posterior neck muscles. This has been checked by electrokymographic experiments, and novocaine injection in the posterior neck muscles will abolish it temporarily. What type of patients present themselves with tension headache? We know that the headache is only one of numerous complaints that the patient presents to the examining physician. The individual is usually apprehensive, ill at ease, often frowns and appears perplexed. He often complains that he does not sleep well. He may also have chest complaints such as chest oppression, palpitation, precordial discomfort and sighing respirations. He may have symptoms referable to the gastrointestinal and to the genitourinary tracts. These individuals are often irritable and are given to crying easily. They do not, for some reason, appear to tolerate noise very well. The tension state merges imperceptibly into the more serious psychiatric disorders. Agitative melancholia begins where it leaves off and it is difficult to know where the dividing line is. These so-called psychogenic headaches far outnumber all the rest of the headaches put together. As to treatment, mild sedatives such as phenobarbital have been of some help. Some physicians like to recommend myanesin, rauwolfia and thorazine compound.

There is a post-traumatic type of headache, which is usually regarded as a variant of psychoneurotic headache. Clinically, it differs in that the history reveals that it usually follows trauma to the head; usually severe enough to produce unconsciousness,

and that it is often accompanied by two other complaints; these patients usually are noise sensitive and have subjective sensations of vertigo, usually on a sudden change of position of the head.

Next in order of frequency of the major types of headaches is that of migraine. What is the mechanism that physiologists tells us about that instigates an attack of migraine? First of all, migraine can be enchanced by histamine; we know that histamine causes dilatation of the temporal artery, and of the middle meningeal arteries. Pulse recordings, taken by various devices on the temporal artery during the migraine attack, will show an increase in the amplitude of the pulse in the temporal artery, and it has also been shown that, after the first hour or more of a migraine, the pulse pressure goes down, but the vessel stands out with a considerable amount of edema around the vessel. The other artery involved in the mechanism is the middle meningeal artery. The external carotid branches, primarily, into the temporal and middle meningeal arteries. These balloon out and pain will result from their dilatation. A migraine patient very often knows that he can cut down the severity of his migraine attack by compressing his carotid artery in the neck. In other words, the ballooned temporal and middle meningeal arteries can be relieved of their stretch if the patient will compress them. There are other physiological data arising from clinical observations made in a whirling chair. If the patient, in a migraine attack, is put in a whirling chair with the head out and the buttocks in, the blood will go up to the head and he will get a worse headache. If his head is to the center of the whirling centrifuge, most of the blood will go to his feet and the migraine headache is reduced. Thus, the phenomena of dilatation of the vessels seems to be the mechanism that sets off a migraine attack.

What sort of an individual is a patient who is suffering from migraine? He is usually a very intense, driving sort of person with a great deal of ambition. Some people regard them as obsessive sort of persons. They are usually in a hurry and, if they have to wait very long to see their physician, they often get extremely upset. The headache usually has its onset at puberty and there is an extremely strong family history in this disease. One thing about migraine which is usually not brought out is that the patient has prodromal symptoms before the attack begins. Many of them are euphoric for a day or so; some get an amazing appetite, or they will eat excessively for at least twelve hours before an attack; others express a great deal of keenness, from an intellectual point of view, and develop many fanciful thoughts. One of the things that has been noted about the migraine patient, not too consistently but often, is a very large output of urine from twelve to twenty-four hours before the attack. As to the attack itself, there is usually an aura of ten to thirty minutes in the usual case. Most of these aurae are visual. The aurae may be rather a feeling as though water were running over the cornea, or snow falling; or it may be cobwebs spinning in front of the visual field, or it may be a darkening in the intensity of the visual field. It may be almost any kind of an ocular phenomena. Sometimes, it may be only in one visual field; sometimes, starting in one visual field and then moving across the whole field of vision. In addition, there may also be sensory phenomena which occur in the migraine patient. He may get a creeping numbness in one-half of the body; he may get paresthesia of a hemisensory type. He may get aphasic and be unable to speak, or to understand speech in the aura period of the migraine attack.

The classic type of migraine headache usually starts out very slowly and gradually builds up to the point where it becomes excruciating and pulsating in character. Some of these people state that their heads feel as if they were sawed in half; one-half hurts and the other half does not. Sometimes, it is only retro-orbital; sometimes, it is temporal and sometimes it is only occipital on one side, but, in most cases before it has reached its height, it has involved half of the head. Then, it may go over and fill the head, as it were. There are some relatively atypical types of migraine headache that are not hemicranial, but the great majority are. For example,

one of these atypical forms of migraine is known as ophthalmoplegic migraine, and is characterized by oculomotor paralyses with a resultant ptosis and fixation of the eyeball; one should pay heed to this type because it often indicates a vascular defect within the brain. Nausea is a common symptom associated with the migraine type of headache, and oftentimes will lead to vomiting. Occasionally, a patient will state that the vomiting will abort the attack. This type of headache usually lasts anywhere from a half hour to three, four, ten hours, or from two to three days. The literature states that this type of headache may even go on for as long as two weeks; they are extremely variable in frequency; one patient will have an attack two, three or four times a week, while others may go on for as long as six months between attacks. Following the attack, the patient usually feels well. A mild state of well being, or euphoria, seems to be the reward for going through the migraine attack.

As to the treatment of migraine, we know that those factors which decrease the amplitude of the pulsation decrease the intensity of the headache. Gynergen is considered an excellent drug and acts by vasoconstriction of the arteries in question; it may be given either intramuscularly in one ampule dosage, or intravenously in one-half ampule dosage. The attack usually terminates in thirty to forty minutes after the injection. It is capable of producing quite a bit of nausea and vomiting, but the patients appear to get a considerable amount of benefit from it. There is also another drug, known as DHE 45, or dihydroergotamine methane sulfanate. Ergotamine, by mouth, in association with caffeine, which is being sold under the form of cafergon, has come into considerable amount of prominence. When the patient feels an attack of migraine coming on, he should take two cafergon tablets at once; one, one-half hour later; another one, one-half hour later, up to six, in the hope that that will be the end of the headache. It seems that each patient has to work out his own individual therapeutic dose for relief from his migraine attack. An interesting sidelight in regard to migraine was brought out by Dr. Carl Pfeiffer of Emory University, who noted that some of his migraine patients lost a considerable amount of urine prior to the attack. He began to study their hematocrits and he found that the blood actually dehydrated in an appreciable number of migraine patients before the attack started. Therefore, he advocated that they avoid foods that caused diuresis. It is remarkable how much the migraine patient is helped by keeping away from foods that contain xanthine compounds such as caffeine, theobromine, and so forth.

There is another condition which some authors appear to consider as a variant of migraine, or as an entirely separate entity, and this is known as histamine cephalalgia, or Horton's syndrome. These patients usually wake up in the early hours of the morning, and usually get their headache after they are awake. These people, with Horton's syndrome, often have their pain confined to their retro-orbital area. The pain is often described as excruciating, burning and boring; it extends into the eye, neck and often into the face along the branches of the external carotid artery. They may have an injection of the sclera, or tear formation in the eye on the painful side and, not infrequently, they will state that the nostril on the painful side is closed during the time of the headache. Any distinction to be drawn between the histamine cephalalgia and migraine could be described as that of a vasomotor phenomenon.

Next in the group of the causes of headache is that of arterial hypertension. The headache of arterial hypertension refers to the frequent, severe and sometimes incapacitating type of headache. These patients do not have the visual or other aurae of migraine. Their headache can be hemicranial but, as a rule, they are more of a generalized nature. The accepted theory is that when the patient gets hypertension, their arteries become stretched and, therefore, render themselves more vulnerable to pain production than they were when the patient was not hypertensive. These headaches are usually relieved by mild sedation and sometimes can receive a considerable amount of help from the use of cafergon.

There are other so-called dilatation head-

aches which have a mechanism which is similar to migraine. For example, there is the individual who has a hangover headache, which is felt to be caused by vascular dilatation. Then, there is the individual who has the hunger type of headache; this is the type of individual who, if he misses a meal, gets a headache. Lastly, there is the caffeine withdrawal type headache, which is said to be of a dilatation etiology. We know that caffeine tends to cause a constriction of the vessels and, if a person who has been a heavy coffee drinker should suddenly withdraw from coffee, there is a rebound dilatation to these vessels. Other dilatation headaches are those that follow epileptic seizures, those produced by allergies, and the headache that one sees in the premenstrual tension week.

Now, let us come to the subject of brain tumors and the headache associated with brain tumors. The mechanism for brain tumor headache is not just due to increased intracranial pressure. Patients with brain tumors, who have little or no increased intracranial pressure, may have a lot more headache than those who have a high intracranial pressure. The mechanisms for production of headache in the brain tumor are multiple; mostly, traction on the blood vessels near the tumor; distortion of veins and venous sinuses produced by shift of the tumor, and also pressure on the sensitive nerve endings of the fifth or the ninth nerve in the head. The headache of brain tumor is not of the type that is seen in migraine, and it is different from the tension type of headache described heretofore. It is usually a constant, deep ache. The headache is usually not associated with nausea, but it is associated wtih vomiting. A brain tumor patient's sleep is not disturbed as one sees in tension type of headache, but rather often has a hypersomnia. Another thing about brain tumor headache is that you can sometimes be helped by a quick test of head jolting. If you have the patient move his head quickly to one side, and then quickly back to the midline and, since the headache is caused by a traction on the blood vessels, the sudden shift caused by this jolt will often make the patient say, "ouch" and makes him tell you that he has a sudden increase in the intensity of his headache. This is relatively peculiar to the brain tumor headache and is of some value diagnostically. Papilledema may not arise very early. The most important ocular manifestation is not papilledema, but diplopia, because the sixth cranial nerve has a long course in the bottom of the middle fossa of the cranium and the pressure often compresses this nerve, causing a weakness of the external rectus muscle and, consequently, double vision, so that diplopia is often a better guide than papilledema as an early sign of brain tumors. Various types of clots on the surface of the brain will also produce headache with the same kind of mechanism of traction and distortion of the vessels. *Subdural hematoma* is usually subacute and, from the time that the patient has received the blow, if he can remember the blow, his headaches seem to begin. The headache is usually generalized, with an increasing hypersomnia to the point where the patient is comatose. Sometimes, the diagnosis of a progressive hematoma is only made when the patient is in coma. *Extradural hematoma,* however, is usually of a more acute nature, caused by much more violent blow on the head, usually with a linear fracture in the thin part of the temporal bone, which severs the middle meningeal artery and subsequent development of a large hematoma, within a period of hours.

Another interesting type of headache, that can be discussed with the general brain tumor group, is that known as Morgagni's syndrome, of hyperostosis frontalis interna hypertrophica. This condition is characterized by a great overgrowth of the diploe and inbending of the inner table of the frontal bone radiologically. The diagnosis of this syndrome has certain characteristics. It is much more common in women than in men. There is oftentimes a widening of the forehead; that is, a sort of ballooning out of the frontal area, a tendency to hirsutism on the upper lip, and a general leathery texture of the skin. Therefore, if one should see a female, between thirty-five and sixty, with a leathery type of skin, a mustache, a wide forehead and a headache, one of the possibilities may be hyperostosis frontalis

interna. The treatment for this condition has been suggested by LeFever and the drug of choice is that of Chondroitin. Six to nine capsules of this substance a day will usually relieve the headache. Why? It has never been explained satisfactorily.

The last type of headache I wish to discuss in this paper is the type which is due to intracranial infections. Purulent meningitis develops rapidly and the diagnosis will become quite evident soon after the onset of the headache. Virus infections of the brain and meninges act quite differently; here, the headache may linger for days and weeks, as the only complaint. Diagnosis is suggested by the presence of the round cells in the cerebrospinal fluid.

Briefly, there are three other types of low grade infection of the meninges which should be included in this group. They are the torular and mycotic meningitis, of which actinomycosis is an example; tuberculous meningitis and luetic meningitis. Tuberculous infection of the meninges and mycotic infections may show themselves only as a complaint of generalized headache for a week or two at the onset. Luetic meningitis can cause headaches alone, not for weeks but for months or years, before other symptoms develop.

Lastly, there is the type of headache that most of us have diagnosed over the telephone. A fifty-six year old female, for example, was standing near her car saying good-bye to a friend when, suddenly, she called out, "Oh, my God"; put her hand up to her head and said that she felt as if someone had hit her on the head with a baseball bat. The pain was excruciating and she fell to the ground, was picked up by her husband, placed in the car and removed to the hospital. The diagnosis was a subarachnoid hemorrhage as result of a sudden rupture of a vessel.

Post-Partum Hemorrhage With Shock

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OF THE more serious complications of parturition, post-partum hemorrhage, with resultant shock, is probably the most serious, demanding prompt and decisive measures to prevent fatal termination. The case to be presented illustrates massive hemorrhage with shock so profound and so prolonged that recovery without permanent brain injury and renal damage was not believed possible. Yet the patient recovered completely, without sequelae.

CASE REPORT

Mrs. V. M., a 32-year-old gravid, white female, entered Latter-Day Saints Hospital on September 11, 1955, at 1:00 a.m., in active labor at term. She had had nine previous pregnancies, including seven uncomplicated full-term deliveries and two spontaneous abortions at two and three months' gestation. All previous deliveries had been normal; however, the first baby subsequently died of causes unrelated to delivery. The patient had had no previous surgery, with the exception of a tonsillectomy in childhood; and the only illnesses other than childhood diseases were annual hay fever and mild asthma, responding well to medical management. The patient's menstrual history had been normal, with menarche at age 14, menses every twenty-eight days, of seven days' duration. The present pregnancy had been uncomplicated throughout.

On admission the membranes were found to be intact, contractions every two to three minutes, of forty-five seconds' duration. The cervix was completely effaced, 9 centimeters dilated. Fetal heart tones were 144 per minute, located in the left lower quadrant. Presentation was cephalic, position left occiput-posterior, station plus one. The remainder of the physical examination was entirely normal.

The patient was taken directly to the birth room, where preparation was done and sterile drapes applied. Vaginal examination revealed the cervix to be completely dilated, the position directly occiput-posterior. A Pomeroy rotation

was carried out, the head turning easily from occiput-posterior to left occiput-anterior, and delivery of a living male infant ensued immediately, at 1:43 a.m. The baby cried spontaneously, and the mother was given 1 ampule of Pitocin and 1/320 grain of Ergotrate intramuscularly after delivery of the placenta, which was intact. There were no repairs, and the immediate condition of the mother was good. The uterus contracted normally after oxytocics, and there was no further bleeding at that time.

At 5:30 a.m., approximately four hours after delivery, the intern and resident were called to see the patient, who had been complaining of pain and swelling in her abdomen. She was found to be in profound shock, with no pulse or blood pressure obtainable. Momentarily no heart tones could be heard on auscultation over the precordium. Pressure on the abdomen caused the patient to moan, however; so shock-blocks were ordered, an intravenous infusion of 6 per cent Dextran was started in each arm, blood was typed and cross-matched, and the attending physician was summoned. A third infusion of 5 per cent Dextrose in water was then started in a leg vein, no more Dextran being immediately available. Abdominal examination showed the fundus of the uterus to be pushed to the right, with a large, soft, tender, well-defined mass on the left, which was diagnosed as a hematoma of the left broad ligament. Blood pressure and pulse were still not obtainable; however, the patient was able to answer questions. Her eyes were noted to wander at intervals, and at times she became semicomatose. Blood was received at 6:15 a.m., and three units were started simultaneously. At 6:30 the blood pressure was 40/30, the pulse 110. At 6:45 the pulse was weak and thready. Blood pressure was not obtainable. One ampule of Levophed was added to a unit of blood, after pumping the blood in under pressure had failed to bring up the patient's blood pressure, and the fourth unit of blood was started. At 8:00 a.m. the blood pressure was obtainable at 50/40, the pulse 90. Preparations had been made to take the patient to surgery, and she was taken to the operating room at 8:20. On the way up in the elevator the patient suddenly screamed out, complaining of "terrific pain" in her back. Palpation of the abdomen revealed that the mass was no longer localized on the lower left. No blood pressure was obtainable.

At surgery a cutdown was done to facilitate pumping in blood under pressure. Even these measures failed to bring the pressure up to measurable levels. It was deemed advisable to proceed with surgery, in the face of absent blood pressure. Cyclopropane was used for induction; from then on the patient received oxygen only. A lower midline incision was made, and on opening the peritoneal cavity it was found to be full of blood and clots, which were evacuated. The uterus was delivered through the incision and the left broad ligament was found to be a massive hematoma, which had ruptured, with a ruptured branch of the left uterine artery visible, pumping out blood. This was clamped immediately, hot packs placed over the viscera, and the procedure stopped while attempts were made to bring up the blood pressure. These attempts failed, no peripheral pulse or blood pressure being obtainable, although a fair aortic pulse was palpable; therefore the procedure was continued, with excision of a major portion of the left broad ligament, because of a general oozing of blood from the damaged tissue. The remainder of the broad ligament was sutured, with complete control of bleeding. The patient had been gray in color throughout most of the procedure. After eleven pints of blood and five pints of Dextram, with continuous intravenous Levophed, the blood pressure suddenly became obtainable at 140/90, fifty minutes after starting surgery. The pulse at this time was 60 per minute. By continuing intravenous Levophed, the blood pressure remained obtainable, alternating between 140 and 30 systolic, and between 80 and 0 diastolic. Closure was then carried out without difficulty, at 11:00 a.m. By this time the patient had developed pulmonary edema. She was given a total of 0.3 milligrams of Crystodigin, as well as oxygen, in the post-anesthesia recovery room. The patient gradually responded, the blood pressure stablizing around 80/70, pulse 100, by 5:00 p.m.

An indwelling urethral catheter had been introduced in the operating room, and the patient began excreting urine immediately after surgery. The urine was grossly bloody at first, but had cleared by the following day. The patient had regained consciousness and seemed mentally alert by 8:00 p.m. of the day of surgery. By the following day, urinary output was adequate, the urine was clear. The patient was awake and alert, with no undue discomfort, and was able to sit on the edge of her bed. A few râles in her chest persisted.

On the second postoperative day, the catheter was removed. The patient was ambulatory. From that time on the patient made an uneventful postoperative recovery. The râles in her chest cleared by the third day, and only a slight cough persisted, presumed to be related to her asthma. Urinalysis was normal, hemoglobin 11 grams, hematocrit 33 millimeters. The patient was discharged on the sixth postoperative day with her baby.

Subsequent follow-up at the attending physician's office failed to reveal any complications. The patient's only complaint was of mild left lower quadrant pain for two weeks, undoubtedly related to absorption of blood remaining in that area.

Summary

A case has been presented of post-partum hemorrhage resulting from rupture of a branch of the left uterine artery with formation of a hematoma of the left broad ligament and accompanied by profound shock of six hours' duration. The patient subsequently recovered completely.

Dislocations of the Head of the Humerus—An Easy Method Of Reduction

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THE reduction of an acute or chronic dislocation of the shoulder presents a number of problems for the general practitioner remote from hospital facilities and assistance of other members of the medical profession. Under ideal circumstances with excellent anesthesia and relaxation, reduction of the dislocation usually is not difficult, particularly if one has trained individuals to assist him in the manipulation. However, reduction under less ideal circumstances may be difficult and tiring.

In order to perform the reduction of a dislocation of the shoulder I have devised a means which is simple and does not require assistance. The operator is not fatigued by the procedure, and since the traction is applied by the operator's body weight his hands are free to aid in the manipulation.

Patients come to my office from four different ski areas, and usually must contemplate long automobile trips before they reach their homes or hospital facilities. A large number of patients with dislocations of the shoulder appear when the snow is soft. Presumably the injury results from the use of the ski poles which force the skier to keep his arms close to his sides. When the skier falls, he usually falls sidewise and the humerus is forced into full extension and abduction. The neck of the humerus pivots about the acromion, and the head of the humerus tears through the capsule, producing a subglenoid dislocation. Following an injury, the patients are transported by the ski patrol to the ski huts where they are intrusted to the care of friends or relatives.

When these patients with dislocations of the shoulder are seen in my office they have all the classic physical findings and are in varying degrees of shock and pain. As soon as possible, patient is given 50 milligrams of Demerol intravenously and 50 milligrams intramuscularly. Administration of intravenous medication is often quite a chore because skiers wear from three to six layers of clothing, and since their apparel is very expensive we do not cut or damage this clothing. Roentgenograms are taken to determine the full extent of the injury. Fracture-dislocations are not treated by this method of manipulation.

Fig. 1. Counter-traction using broad strap attached to ring in the wall.

Reduction of the dislocation is accomplished in the following manner (Fig. 1): The patient is placed in a supine position on a rolling table which is moved to a wall in which a large metal ring is solidly anchored. The patient's normal side is placed next to the wall. A broad canvas strap is then passed through the ring and around the patient's chest just inferior to the axilla.

Padding is placed under the canvas strap so that there is no danger of injury to the chest wall. This strap and the ring provide counter-traction. The patient is instructed in the use of Trilene gas through the usual Duke Trilene mask. The humerus is slowly abducted and the elbow flexed to 90° with the forearm pointing toward the ceiling

Fig. 2. Method of reduction showing counter-traction and traction.

(Fig. 2). The operator stands facing the injured side of the patient with the patient's injured forearm adjacent to the operator's body. A rubber or felt pad is placed on the volar surface of the forearm. A second broad strap is then passed over the forearm pad and around the operator's hips. The patient is asked to breathe through the Trilene mask and instructed to relax as much as possible. The operator gradually leans backward into the second strap using his weight to perform direct lateral traction on the dislocated humerus. The traction is steady and the operator's hands are free to hold the forearm. Usually the humerus is reduced with a sound which is audible throughout the room.

As soon as reduction is accomplished the arm is placed in the position of abduction and internal rotation and a roentgenogram is taken. If the roentgenogram demonstrates satisfactory reduction, an absorbent cotton pad is placed in the axilla to absorb perspiration, and the arm is immobilized in a sling with the elbow at a right angle. The arm is bound to the chest by a wide bandage

Fig. 3. Immobilization of reduced dislocation; cotton pad placed in arm pit to absorb perspiration is not shown in drawing.

which encircles arm and thorax (Fig. 3). Immobilization is continued for three weeks to allow for repair of the capsule. Immobilization in patients over 50 is necessarily shortened because of the dangers of atrophy of shoulder muscles and adhesive capsulitis in these elderly patients. Following immobilization active motion is encouraged.

This method of reduction offers numerous advantages over the usual methods. The Kocher maneuver presents considerable difficulties and dangers, and it is possible to produce a fracture of the surgical neck of the humerus by this maneuver. The Hippocratic method of reduction of a dislocation of the shoulder by insertion of the foot into the axilla places a great deal of pressure on the axillary vessels and nerves and is apt to damage them. In addition, both of the methods require the traction and a test of strength between the patient and the operator, resulting in considerable fatigue. Muscle fatigue may be a very important consideration for the general practitioner since the next patient may require precise work which may be impossible because of the physician's muscle fatigue.

It would seem to be elementary that, if a patient with an acute lower respiratory infection were ill enough to require hospitalization, an initial diagnostic chest x-ray would be mandatory, and that for pneumonias, additional progress films would be in order.—C. Wesley Eisele, M.D., Virgil N. Slee, M.D., and Robert G. Hoffmann, Ph.D., Ann. Int. Med., Jan. 1956.

Intermittent Positive Pressure Breathing—Its Use and Abuse*

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VARIOUS types of pressure breathing apparatus in the treatment of different forms of cardiopulmonary difficulties have been available for many years. The use of intermittent positive pressure breathing on inspiration was first introduced by Motley and his coworkers in 1947,[1] and its use in combination with bronchodilator drugs was reported by him later.[2] In the Denver area, the Bennett machine became available to us in September, 1951, when the first group of cases of emphysema with and without silicosis in miners was treated at General Rose Hospital. Later the machine was used in other hospitals for adults as well as for asthmatic children at the Jewish National Home for Asthmatic Children and children with fibro-cystic disease (mucoviscidosis) at Children's Hospital as well as at home. It is the purpose of this paper to present some of the uses of IPPB/I (Segal[3,4]) as well as its abuses.

In the past few years various investigators[5,6,7] have stressed the fact that the disability of pulmonary disease is often more physiologic than pathologic. The disturbed function appears to center around the problem of airway obstruction as a result of bronchiolar narrowing and is principally due to the following factors:

1. Accumulated secretions and exudates —This is true whether the sputum is the thick, inspissated white mucoid substance of the asthmatic (up to and including the "sago granules" or mucoid "pearls") or the frankly purulent substance of the infected bronchitic or bronchiectatic.

2. Mural thickening—Chronic inflammatory processes of all kinds cause an actual thickening of the bronchial mucosa. The musculature of the bronchi has been shown to hypertrophy in long standing bronchopulmonary disease and especially in emphysema.

3. Mucosal edema.

4. Bronchospasm—This has been found to be highly important in the production of dypnea in patients with fibrosis and emphysema regardless of the cause of their condition.

All workers feel that treatment must be directed to the relief of infection, bronchospasm, impaired breathing mechanics and hypoxia. Impaired diaphragm movement, loss of lung elasticity, and bronchial obstruction, singly or in combination, have produced severe physical limitations of breathing. This is true to such an extent that the usual methods of aerosol therapy are ineffective as the result of diminished tidal volume and uneven distribution of inspired air through the lungs and particularly the bases.

Since all forms of chronic pulmonary disease present the major characteristics outlined above it would appear that the therapy to be described would apply in one measure or another to all of them. These include chronic bronchitis bronchiectasis, pulmonary fibrosis of various forms, bronchial asthma, pulmonary emphysema and suppurative diseases of the lungs.

The application of positive pressure to the airway during the inspiratory phase of respiration will be referred to as IPPB/I. The expiratory phase of respiration is entirely passive. The devices usually consist of an inspiratory demand valve operating on either a flow-sensitive or pressure-sensitive principle. The valves are used with oxygen, oxygen-air mixtures, or air. Experience has been had with the Bennett

*Presented to the Colorado State Medical Society in Denver on September 23, 1955.

(V. Ray Bennett Co., Los Angeles, California), MSA (Mine Safety Appliance, Pittsburgh, Pa.) and Halliburton (Duncan Oxygen Co., Duncan, Okla.) valves. By using increasing pressures of 10 centimeters of water up to 20 to 25 centimeters of water, patients have been given considerable relief of symptoms with increased expectoration, decreased wheezing, increased exercise tolerance, and increased appetite. In occasional instances, an improvement in diaphragmatic motion has been noted.

Noehren[8] classifies this treatment as "intermittent ventilation therapy" rather than intermittent positive pressure breathing, feeling that the physiologic effects are accomplished by the flow of air more than by the pressure under which the air flows. Although arguments[9] have been produced to the effect that IPPB/I with aerosols add nothing to the effect of aerosols as produced by hand bulb or other pressure devices, studies have indicated the following values to be derived from the former:

1. More uniform alveolar aeration—Tracings show that great improvement in ventilation volume is accompanied by a decrease in the obstructive portion of the expiratory curve.

2. Improved distribution of aerosol.

3. Bronchial drainage—It has been suggested that mucus and secretions are washed or pushed further down by the action of the positive pressure on inspiration. This is not true and in point of fact, secretions are expectorated much more easily because the peak expiratory flow velocity is greater than the peak inspiratory flow velocity. The net result is to work secretions outward in an expectorant-like action. Normal cough works on a similar principle with a similar air flow velocity mechanism.

Technic: The patient is seated or lying down and the machine placed in position. Our experience has been with oxygen alone although good results have been reported with air and oxygen-air mixtures. The separate valve to the nebulizer is opened slowly so that a fine mist is seen issuing from it before reattaching it to the machine. The flow sensitive or pressure valve is opened to 10 centimeters of water pressure and the mouthpiece or mask is applied to the patient's face. It is of great importance that the mask be properly fitted because any leak interferes with smooth operation of the cut-off valve on expiration. For this reason, many workers, including the author, prefer the mouthpiece provided there is no excess salivation. When treatment is started there is some tendency to hyperventilate with dizziness, tingling, and even mild tetany. This can be avoided if patients are instructed to breathe deeply and slowly at 10 to 12 respirations per minute with complete expiration. If coughing ensues, the mouthpiece or mask is removed until it is over and then treatment resumed. Pressures may gradually be raised until the mask pressure is 20 centimeters of water.

The procedure may be frightening to the uninitiated and the time spent in explanation is well worthwhile. Goddard[10] in working with children places them on a high swivel stool which is called the "pilot's seat" and every effort is made to simulate the actions of a "jet pilot on a mission flying high up in the skies."

Treatments are usually given for periods of twenty minutes, three to four times daily. These are continued as long as some improvement is shown and then reduced as improvement it seen.

Drugs for use in nebulizer: The nebulizer used is the vaponefrin nebulizer DeVilbiss No. 40, or the Asthmanefrin nebulizer. It is unnecessary to remove the rear cork from the nebulizer since this increases the spray and the solution should last for the entire period of treatment (twenty minutes) and increased mist is not required.

1. Bronchodilator drugs — These drugs provide rapid and effective relief in patients with bronchial asthma and other bronchospastic states encountered in almost all chronic pulmonary conditions. They are adrenergic drugs with sympathomimetric activity and act by virtue of their spasmolytic effect on the smooth musculature of the tracheobronchial tree. In addition, these aerosols diminish edema and congestion of the bronchial mucosa by vasoconstriction.

a. Vaponefrin (2.25 per cent racemic Epinephrine). Breatheasy and Asthmanefrin are preferred by some.

b. Isuprel 1:200 (n-isopropyl arterenol).

c. Neosynephrine 0.25 to 1.0 per cent (phenylephrine).

d. Aerolone 50 (a combination of aludrine, clopane and procaine in a propylene glycol base).

e. Dylephrine (2.5 per cent racemic epinephrine plus atropine).

My own preference is for the combination of Neosynephrine in amounts up to 0.5 c.c. with one of the other materials (usually Isuprel) also in amounts up to .5 or .8 c.c. Systemic side reactions such as headache, tremor, and tachycardia are only infrequently encountered but must be watched for since they are frightening and should act as a signal for a change to one of the other preparations. Their long continued use sometimes results in the development of a refractory state with the need also for a shift to other aerosols of this group.

Recently Segal[11] has reported on the use of Pamine, 0.33 mg., dissolved in 1 c.c. of water, and other anticholinergic drugs for use with IPPB/I in status asthmaticus. Insufficient experience with these substances precludes their recommendation for routine use at this time.

2. Antibiotics — The use of antibiotic therapy by aerosol in bronchiectasis, lung abscess, chronic bronchitis and acute and chronic sinusitis has been thoroughly detailed in the literature. Most antibiotics are now available for nebulization but there is still sharp division of opinion as to their effectiveness given in this fashion over the parenteral route. The choice of drug will depend of course on the predominant organism isolated on culture and its sensitivity as determined by disc method.

In using antibiotics by aerosol one must bear in mind that the associated asthma or emphysema may not improve, or even grow worse, due to the intensification of bronchospasm induced by the mist itself. Where such background pathology exists in addition to the presenting picture of bronchitis, it would be best to gve the antibiotics parenterally.

3. Aerosols used to liquefy sputum:

a. Detergent preparations:

Ceepryn.

Sodium Lauryl Sulfate (Dupanol C).

Zephiran 1:1000.

Alevaire—An excellent preparation but either the alkalinity or hypertonicity may be responsible for local bronchial irritation and bronchospasm. We are presently working with a new preparation of Isuprel in combination with Superinone, the active detergent present in Alevaire, used with water as the diluent in the nebulizer. This may overcome some of the previous described side reactions.*

b. Mucolytic enzymes: Tryptar in doses of 50,000 units t.i.d. is sometimes effective but even with proper precautions may cause increase in bronchospasm. Pancreatic dornase (Pancreatic desoxyribonuclease) in doses of 50,000 to 100,000 units t.i.d, dissolved in Sorenson's buffer solution, as is Tryptar, may be of occasional value. The uses for IPPB/I may be listed as follows:

1. Relative Indications.

a. Status asthmaticus—Treatment should be given as often as necessary until other drug therapy and steroids have a chance to "take over."

b. Pulmonary emphysema—Best results are seen in those patients who are not too far advanced. Most reports in this type of case have been enthusiastic. In spite of earlier reports, we cannot confirm long lasting good results. Treatment should be maintained for long periods, and many patients have been encouraged to purchase their own machines for use at home.

c. Bronchiectasis and chronic bronchitis—Of real value where the patient is too exhausted to cough effectively or where there is inadequate ventilation to reach affected areas. In preparation for the surgery of bronchiectasis, IPPB/I is helpful.

d. Trauma to chest wall with or without fracture of ribs may inhibit cough and predispose to atelectasis. Routine use of IPPB/I should be helpful.

e. Exposure to irritating fumes or gases should be treated prophylactically with IPPB/I. Its beneficial effect even after pulmonary edema has occurred is often striking.

f. Acute anoxia induced by superimposing

*Supplied for study by Winthrop-Sterns.

an acute respiratory infection upon an already limited pulmonary function is a "must" for IPPB/I and such cases will show striking improvement when properly handled.

g. Various types of industrial lung diseases, when emphysema and bronchospasm are the presenting disabling features, can be treated effectively with IPPB/I.

h. Cystic fibrosis of the pancreas (mucoviscidosis) in children with the disability of bronchiectasis, bronchitis and emphysema have been helped with IPPB/I.

2. Absolute indications: Some of the above might be listed, such as acute anoxia, but there can be no question of its value where artificial ventilation is required. Some machines are not only equipped with demand valves on inspiration but may be also automatic and thus work in apneic patients. Such cases include: Poliomyelitis and other neurological disorders, drug coma patients, postoperative complications, respiratory acidosis, etc.

Abuses of IPPB/I:

1. Medical contra-indications.

a. Shock of any degree—IPPB/I may be harmful by increasing intrathoracic pressure and further limiting return of blood to the heart.

b. Recent hemoptysis.

c. Recent spontaneous pneumothorax.

d. Recent myocardial infarction and coronary insufficiency are not absolute contra-indications but care must be exercised in using proper bronchodilator drugs.

e. Large pneumatocele may lead to spontaneous pneumothorax unless carefully observed for increase in size of air pockets as treatment is continued.

2. Technical abuses:

a. Indiscriminate prescription — Many physicians are prescribing IPPB/I in cases where no possible indication exists. This is due in large measure to inadequate understanding of the physiology involved and what can be expected of treatment.

b. Inadequate orders for treatment — In many institutions treatment is being ordered without regard for mask pressures, time or frequency of treatment, bronchodilators and/or detergent or other vehicles. The nursing service is in the peculiar position of holding up treatment because of insufficiency of orders.

c. Inadequate training of unqualified personnel—IPPB/I can render useful service only if given properly by trained personnel. It is the opinion of the author that treatment should be given by trained nurses, supervised by physicians interested in this form of treatment. Too often the machines are given over to nursing aides who have been inadequately trained, with resultant poor results.

Summary

IPPB/I is a useful method of treatment of certain forms of pulmonary disease where airway obstruction is due to spasm, accumulated secretions, edema, etc., and where inadequate ventilation can be aided by bronchodilators brought to underventilated areas by positive pressure. As with all new methods of treatment, proper understanding of the physiologic principles is important if such method of treatment is not abused and thus brought into disrepute.

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Electroconvulsive Therapy And the Cardiac Patient*

S. C. Percefull, M.D.
DENVER

Many internists and general practitioners will appreciate knowing more about the circulatory risks imposed by electroconvulsive therapy.

ELECTROCONVULSIVE therapy is well established as one of the most important tools in management of psychiatric disorders. It is sometimes life saving. Its early use was attended by over-caution and many individuals who would have benefited greatly were thus denied electric shock because of advanced age, hypertension, coronary insufficiency, arteriosclerosis, myocardial infarction, tuberculosis, malignancies, arthritis and other diseases. Subsequently the pendulum has swung in the other direction with many psychiatrists administering electroconvulsive therapy in the presence of cardiovascular disease, with little hesitation, in a wide variety of mental disorders.

Occasionally the internist is asked to evaluate a cardiac patient and indicate whether he is or is not able to tolerate electroconvulsive therapy. The internist is apt to know little about the altered physiology occurring in convulsive seizures, the cardiac load imposed thereby, and the risks involved.

Fatalities during electroconvulsive therapy are admittedly rare, occurring at the rate of 0.06 per cent,[1] probably less than that of general anesthesia. This is in accordance with the observation that death rarely occurs with the grand mal seizures of epilepsy. Kalinowsky and Hoch[2] state that they remember no patient developing cardiac symptoms during or shortly after electroconvulsive therapy, though their patients have not been followed with electrocardiograms. Ebaugh,[3] however, reported two cases of sudden death with electroconvulsive therapy, one dying of acute myocardial infarction and the other apparently of respiratory failure. Both patients had received clearance by cardiologists. Will, Rehfeldt and Newmann[4] collected thirty-three fatal cases, most of which were of obscure cause since the descriptions of respiratory and cardiac systems were not detailed, no electrocardiograms were done, and the pathologic findings present at postmortem were inadequate to explain the causes of death. It is believed that most of these deaths were of cardiovascular origin, though respiratory complications are more commonly seen.

What happens during an electrically induced grand mal seizure? Initially, increased sympathetic tone occurring because of direct autonomic stimulation and profound muscular activity provokes a sinus tachycardia. Idioventricular rhythm, premature auricular and ventricular contractions may occur, as well as increased venous pressure and increased arterial pressure. Prolonged apnea follows with the patient performing the Valsalva maneuver at maximum expiration. As the Valsalva maneuver ceases, pooled blood in the ex-

*From the Vanden Bosch-De Roos Clinic, Denver, Colorado.

tremities and trunk rushes into the right heart, dilating the right atrium and thereby increasing the amplitude of the P waves of the electrocardiogram. The load on the right ventricle increases; S T depressions appear in leads facing that chamber, and right axis deviation is often present. The arterial blood oxygen saturation is decreased on the average from 18.82 volumes per cent before treatment to 12.82 volumes per cent immediately after. The pH of the blood may fall from 7.445 to 7.142,[5] the resulting acidosis producing vagatonia. Several minutes after onset of the convulsion, bradycardia usually occurs due to the vagal excitation, and various arrhythmias result, probably because of SA node depression and myocardial anoxia. Ectopic auricular and ventricular systoles are common; shifting pacemaker, AV block, nodal rhythms, and SA block are seen,[6] and auricular fibrillation has been described by Craddock and Gilbert.[7]

The QT interval is commonly shortened in normal individuals after electroconvulsive therapy, and the T waves are heightened. Acidosis tends to increase T wave amplitude,[8] as does liberation of potassium from injured muscle cells; probably the former factor is of more significance here. Interestingly enough, the T wave inversion of old infarcts and hypertrophy patterns may be temporarily converted to normal following electroconvulsive therapy. Increase in serum potassium on the other hand will invert the abnormal T waves further. Lepeschkin[9] has shown that the immediate T wave elevation is similar to that after exercise and gives way in three to twelve minutes to flattening or inversion in II and III. If ST-T depression persists after treatment he regards this as evidence of coronary insufficiency.

According to Bankhead,[10] unfavorable cardiac reactions are due to (1) vagal overactivity, and (2) ectopic disturbances due to other causes. Suppression of the SA node, necessitating the appearance of ectopic auricular or ventricular pacemaker, is potentially dangerous and has been observed in post-shock patients exhibiting vascular collapse, gray color, apnea, salivation, muscular relaxation, increased bronchial secretion, nausea and vomiting—all signs of extreme vagal excitation. Bankhead reports two sudden deaths under such circumstances, and recommends atropinization (1/50th to 1/30th grain intramuscularly thirty minutes before therapy) in patients who exhibit such symptoms in previous electroconvulsive treatments. Convincing evidence is presented in his series showing that these signs of vagal over activity can be aborted by premedication. Hejtmancik[8] describes sudden death during electroconvulsive therapy in a sixteen-year-old girl whose preliminary electrocardiogram exhibited a PR interval of 0.22 seconds at a ventricular rate of 100, flat T in lead I and negative T in IV F—the electrical manifestations of vagatonia. She apparently died of cardiac arrest. Altshule's two patients who had severe vagatonic reactions also were found to have hyper-irritable carotid sinuses, and the determination of carotid sinus irritability in the pre-shock work-up of patients is emphasized by him.

Arrhythmias may also result from myocardial anoxia which occurs during the apneic period. Bursts of premature ventricular contractions are potentially serious since they may preface ventricular tachycardia and fibrillation, and maintenance of an adequate airway cannot be overemphasized. Rapid oxygenization is the most important emergency measure. If the patient shows frequent premature contractions before treatment is begun, quinidine four times daily is indicated. Of course, the patient who has been in congestive failure should be digitalized.

Curare was introduced with the purpose of diminishing the violence of the convulsions, thus reducing strain on the skeletal and cardiovascular systems. By inhibiting cholinesterase it may dangerously augment the vagatonic state, however, and deaths have resulted from its use.

Moore has shown the more or less minimal risk involved in treating cardiac patients. In his series of 238 known cardiacs were five with artio-ventricular block, eight with bundle branch block, two with aortic

stenosis, seven with mitral stenosis. One patient who had had previous myocardial infarctions, experienced another shortly after her third electroconvulsive treatment, apparently recovered but died suddenly several weeks later. The remaining patients survived. One hundred ninety individuals with hypertension were treated without incident. Bankhead[10] successfully treated individuals who had previous myocardial infarctions—one case six weeks following the infarction—and three patients who had had previous bouts of congestive failure.

Rymer[12] describes one sudden death in approximately fifteen thousand electroconvulsive treatments. The patient received medical clearance, yet succumbed during the first treatment. Coronary sclerosis was demonstrated at postmortem.

It now appears that all of the cardiovascular contra-indications to electroconvulsive therapy are only relative and the risks are generally small. The most concern should be given to the patient with coronary insufficiency, since he is most apt to develop arrhythmias and suffer from myocardial anoxia. If his psychiatric condition is such that it threatens life, the risk of electroconvulsive therapy should be accepted and the patient treated. On the other hand, if his depression is not so serious, perhaps electroconvulsive therapy should be withheld. Agitated depression in an individual may be responsible for an increased cardiac load as well as for hypertension, and these factors deserve consideration in making the decision.

Aneurysm of the aorta was formerly considered an absolute contra-indication to treatment, but cases have occasionally received electroconvulsive therapy without disaster.

Kalinowsky[2] has said, "In several cases where cardiologists have postulated a contra-indication to electroconvulsive therapy, we were forced by a serious psychotic state to ignore this contra-indication and in none of these patients did we encounter difficulty."

Summary

Fatalities due to electroconvulsive therapy are rare and are generally of cardiovascular origin relating to extreme vagatonia and cardiac arrest.

Patients with known heart disease, particularly those with coronary insufficiency, are more likely to experience cardiac complications, and appropriate medication is often indicated. Likewise, individuals exhibiting signs of vagatonia should be premedicated with atropine.

The cardiovascular apparatus of all candidates for electroconvulsive therapy should be carefully evaluated.

The internist may define the nature and extent of heart disease in the individual patient, but the final decision as to whether he should undergo electroconvulsive therapy rests with the psychiatrist, much as the final decision and responsibilty for laparotomy rests with the surgeon.

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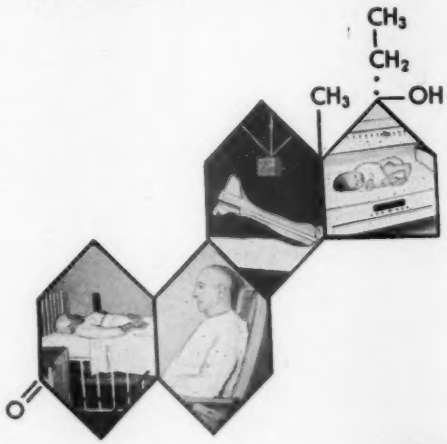

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[1]Albertson, H.A. and Trout, H. H., Jr.: *Antibiotics Annual* 1954-55, Medical Encyclopedia, Inc., New York, N.Y., 1955, pp. 599-602.

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ACHROMYCIN ACHROMYCIN

The Washington Scene

A monthly news summary from the nation's capital by the Washington Office of the A.M.A.

Before the end of the year hundreds of thousands of dependents of military personnel, living in all parts of the country, should be receiving their medical care from private physicians and in private hospitals under the new program authorized this year by Congress. While Defense Department has not yet completed regulations to implement the act, the law itself lays down the basic principles governing the program.

The House Armed Services Committee first attempted to decide on a system or systems for furnishing private care, through Blue Cross, Blue Shield, arrangements with state medical societies, commercial insurance or "home town care," such as Veterans Administration successfully employs. But the committee gave up on the problem, and Congress finally tossed it to the Secretary of Defense by stating in the bill that he shall ". . . after consultation with the Secretary of Health, Education, and Welfare . . . contract for medical care for such persons . . . under such insurance, medical service or health plan or plans as he deems appropriate." A Defense Department task force now is attempting to decide how to work out the contracts.

Although several groups of dependents will be entitled to medical care, only wives (or husbands) and children of men on active duty will be certified for civilian care. The others will be admitted to military medical facilities on "availability of space" basis. While generally spouses and children of active duty personnel will have a choice of private or military care, there is this limitation: The Secretary of Defense may designate certain areas where private care will not be authorized, if in his opinion those areas have military facilities adequate to care for the service families.

Dependents will be required to pay the following charges: For care in military facilities, subsistence and "in-hospital" charges (set by Secretary of Defense and currently $1.75 per day); for private care, the same fees or the first $25, whichever is the larger.

The time limit on private care is 12 months, but if hospitalization still is required after this period the dependent will be protected. In this case the Defense Department will transfer the dependent to a military facility or will make direct payment to a private hospital.

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Although regulations will spell out limitations and authorizations in more detail, the law makes the following provisions:

Care in military facilities to include: 1. Diagnosis, treatment of acute medical and surgical conditions, treatment of "contagious diseases," immunization and maternity and infant care. 2. Hospitalization for nervous and mental disorders, chronic diseases or elective medical and surgical treatments **but only in "special and unusual cases"** and for not for more than 12 months. This would be provided at the discretion of the Secretary of Defense. Dental care not authorized except in unusual cases while abroad or at remote stations in the U. S.

Private care will include: 1. Hospitalization in semi-private accommodations up to one year for each admission, including all necessary services and supplies furnished by hospital. 2. Medical and surgical care incident to hospitalization. 3. Complete obstetrical and maternity service, including prenatal and postnatal care. 4. Physician or surgeon's services prior to and following hospitalization for bodily injury or surgery.

Under the private care program, some services may be furnished outside the hospital, such as surgery in a doctor's office, x-rays or laboratory tests, "but not what is normally conceived to be out-patient care." If experience shows they can be afforded, additional services may be authorized, but whatever the scope of private care, it cannot exceed that furnished in military facilities. Out-patient care will be furnished by military facilities, but "uniform minimal" charges may be imposed as a restraint on excessive demands.

Notes:

Federal appropriations for medical research are at an all-time record, explained in part by Senate approval of a 48 per cent increase over last year's funds.

Dr. Lowell T. Coggeshall, special assistant to HEW Secretary Folsom, believes some "wise changes" should be made in medical economics to facilitate payment for the "spectacular" new medical services. He expressed his views in addressing a group at the University of Pennsylvania Medical School.

Russia and eight satellites, out of active participation in World Health Organization for more than six years, now are back in; they agreed to pay 5 per cent of past-due assessments over a 10-year period.

The highway program contains a provision for a one-year study of traffic safety, a problem in which the American Medical Association has been actively interested for years.

ORGANIZATION

PRELIMINARY INFORMATION
on the
86TH ANNUAL SESSION
of the
COLORADO STATE MEDICAL SOCIETY

September 5-8, 1956

Stanley Hotel, Estes Park

WEDNESDAY, SEPTEMBER 5

Morning

"FUTURE OF MEDICAL PRACTICE"

Guest Speakers:
William A. Sawyer, M.D., Rochester, N. Y.
Francis Hodges, M.D., San Francisco
Joseph D. McCarthy, M.D., Omaha
Panel Discussion

Afternoon

Golf Tournament, Fishing Derby, Trap Shooting, Bowling

Evening

Informal Dinner—Physicians, guests and their wives, followed by a stag for men and another stag for wives.

THURSDAY, SEPTEMBER 6

Morning

Indoctrination Course All Day

"RADIOACTIVE ISOTOPES IN DIAGNOSIS AND TREATMENT"

Speakers:
Thad Sears, M.D., Denver
James W. Lewis, M.D., Colorado Springs
Robert O. Beadles, M.D.
Matthew Block, M.D., Denver
John Lawrence, M.D., Berkeley, Calif.
Panel Discussion

Incoming Presidential Address — George R. Buck, M.D., Denver

Afternoon

Sports Tournaments

Evening

Outdoor Chuck Wagon Meal, Followed by Square Dancing

FRIDAY, SEPTEMBER 7

Morning

"THE PATIENT, THE DOCTOR AND THE HOSPITAL"

Speakers:
George Bugbee, Nw York City
John S. DeTar, M.D., Milan, Michigan
Leland McKittrick, M.D., Brookline, Mass.
Kenneth Babcock, M.D., Chicago
Panel Discussion

Afternoon

Sports Events

Evening

Dinner Dance

SATURDAY, SEPTEMBER 8

Morning

Breakfast Ride

"NEUROLOGIC DISORDERS"

Speakers:
Paul Wetzig, M.D., Colorado Springs
Donn Barber, M.D., Greeley
George W. Holt, M.D., Denver

Summary of Actions of House of Delegates

Installation of New Officers

Report of Necrology Committee

Lloyd Florio, M.D., Denver

Panel Discussion

This is a thumbnail sketch of the program.

The Woman's Auxiliary plans an interesting schedule of events for wives of physicians in attendance.

Hotel and motel reservations can be made through the Chamber of Commerce, Estes Park.

THE COMPLETE PROGRAM WILL BE PRINTED IN THE AUGUST ISSUE OF THIS JOURNAL.

Component Societies

LARIMER COUNTY

The Larimer County Medical Society held its regular meeting in Estes Park June 6. After dinner, Dr. Horace Campbell, chairman of the CSMS Automotive Safety Comomittee, talked about safety features in new automobiles. The film, "The Search," was shown following Dr. Campbell's talk. Next meeting is scheduled to be held in Fort Collins in September.

W. S. ABBEY, Secretary.

CHAFFEE COUNTY

Chaffee County Medical Society held its regular meeting in Salida June 5. Following dinner, Drs. James Perkins, Constitutional Secretary, and Bernard T. Daniels, chairman of the Comprehensive Care Committee, discussed State Society business.

STEPHEN B. PHILLIPS, Secretary.

Obituaries

HARRY ALLISON ALEXANDER

Dr. Alexander of Boulder was found dead in his home April 17, 1956. He had suffered a heart

attack. He was born in 1899 in Indiana; received his M.D. degree from Indiana Medical School in 1926. He came to Colorado to establish his practice in 1931 at Boulder and was a member of both State and County Medical Societies.

Dr. Alexander served as a Major in the Army Medical Corps during the Second World War. He is survived by his widow, Rebecca; a daughter and two sons.

IRA DIXON

Dr. Ira Dixon died May 16 at the Veterans Hospital. He was born September 4, 1901, in Buffalo, New York, and graduated from Dartmouth College and Harvard Medical School. He came to Denver after his discharge from the Army with the rank of Lieutenant Colonel and established his practice here.

Dr. Dixon was a Diplomate of the American Board of Internal Medicine, a Fellow of the American College of Physicians. He was a member of staff of both the V.A. Hospital and of the University of Colorado Medical School.

Survivors include a daughter, Mary; one sister and one brother.

GUY ASHBAUGH

Dr. Ashbaugh, retired Weld County physician, died April 20 of injuries suffered in an auto accident in Jefferson County.

Dr. Ashbaugh was born at Bald Mountain, Colorado, in 1881. He received his M.D. degree from Denver and Gross Medical College in 1907. He practiced in Colorado until his retirement in 1951.

MALCOLM C. McCORD

Dr. McCord died May 24, 1956, at his home, 1125 South Fairfax. He was born in 1921 at Cincinnati, Ohio, and received his early education in Ohio. He was a graduate of Dartmouth College and received his M.D. degree from the University of Michigan in 1945.

In 1951 Dr. McCord came to Colorado. He was an instructor in Internal Medicine at Colorado General and at Denver General Hospitals. He was a member of Colorado State Medical Society.

Survivors include his wife, Jeannette, and one son.

ELEANOR G. MEEK

Dr. Meek died May 28 at St. Luke's Hospital following a series of infections which had lasted for several months.

She was born in Denver May 7, 1910, and attended Denver schools. In 1932 she graduated from Denver University and worked as a medical technologist for several years, serving as seriologist at the Colorado State Board of Health Laboratory and later at Fitzsimons Hospital.

In 1950, Eleanor Meek received her M.D. degree from the University of Colorado School of Medicine. After interning she went on to complete her residency in medicine at the V.A. Hospital.

Dr. Meek was a member of staff at St. Luke's, St. Joseph's, Presbyterian, Mercy and General Rose Hospitals. She was a member of the American Medical Association and of the Colorado and Denver component societies.

A student loan fund is to be established in memory of Dr. Meek at the University of Colorado School of Medicine.

Survivors include her aunt, Mrs. Irene Lamont of Denver, and two cousins.

THIRD ANNUAL SAINT JOSEPH'S HOSPITAL CLINICS

All physicians are cordially invited to the Saint Joseph's Hospital Annual Clinics to be held August 2, 3, 4, 1956, at St. Joseph's Hospital.

The Clinics are designed to present a postgraduate review of the practical approaches to General Medicine, Obstetrics, Surgery and other fields of specialization along with recent advances.

These clinics have been approved for credit by the American Academy of General Practice.

In addition to the scientific sessions, the hospital staff will be hosts at luncheon Thursday and Friday and at an informal party Friday evening for registrants and their wives.

Address inquiries to: Mrs. Hogue, secretary to the administrator, 1818 Humboldt Street, Denver, or call MAin 3-6121, Extension 601.

OB-GYN SPECIALISTS RENAME NATIONAL SOCIETY

The American Academy of Obstetrics and Gynecology has been renamed The American College of Obstetricians and Gynecologists, Dr. Ralph E. Campbell, Madison, Wisconsin, President of the College, has announced. The new name became official on May 11, following action by the Executive Board to carry out the wishes of the Fellows of the organization as voiced in a vote taken at the Annual Meeting in Chicago, last December.

The organization was first incorporated in August, 1951. It now has 3,831 Fellows and expects to induct some 500 new Fellows at its 1956 meeting which will be held at the Palmer House, in Chicago, on November 7, 8, and 9. Its headquarters are located at 116 South Michigan Avenue, Chicago 3, Illinois.

PAN-PACIFIC SURGICAL ASSOCIATION

The Seventh Congress of the Pan-Pacific Surgical Association will be held in Honolulu, Hawaii, November 14-22, 1957. All members of the profession are cordially invited to attend and are urged to make arrangements as soon as possible if they wish to be assured of adequate facilities.

An outstanding scientific program by leading surgeons with sessions in all divisions of surgery and related fields promises to be of interest to all doctors.

Further information and brochures may be obtained by writing to Dr. F. J. Pinkerton, Director General of the Pan-Pacific Surgical Association, Room 230, Young Building, Honolulu, Hawaii.

News Briefs

The Department of Otolargyngology, University of Illinois College of Medicine, announces its Annual Assembly in Otolaryngology from October 1-7, 1956. The Assembly will consist of an intensive series of lectures and panels concerning advancements in otolaryngology, and evening sessions devoted to surgical anatomy of the head and neck and histopathology of the ear, nose and throat. Interested physicians should write direct to the Department of Otolaryngology, 1835 West Polk Street, Chicago 12, Illinois.

Doctors who are giving third of "booster" shots of Salk polio vaccine are violating rules of the state's vaccination program. This was the report of A. A. Jenkins, M.D., State Health Department official, who said that provisions have not yet been made by the U. S. Public Health Service for more than two doses of vaccine for eligible individuals. Dr. Jenkins, who is chief of the department's Bureau of Disease Control, said that "several reports have reached us of instances in which polio vaccine supplied by the federal government has been used for third or booster shots."

Obituaries

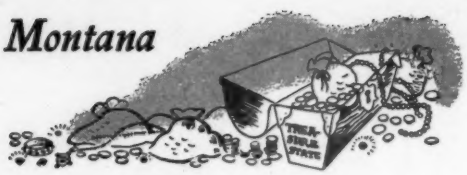
ROBERT T. JELLISON

Robert T. Jellison, M.D., 60, prominent Salt Lake City physician, died May 17 after a coronary occlusion. He was a staff member of St. Mark's Hospital for about forty years.

Dr. Jellison had served on the medical staff of Kennecot Copper Corporation, Western Division, from 1915 until his retirement three years ago. He was a member of the El Kalah Temple of the Shrine and was a 32nd degree Mason. A veteran of World War I, he served as a captain of the 145th Field Artillery. Dr. Jellison was also a member of the Salt Lake County Medical Society and the Utah State Medical Association.

WILLIAM H. BROOKS

William H. Brooks, M.D., 39, died of a heart attack May 4. Dr. Brooks had been Monticello's only physician since June of last year. He came to Monticello from Rome, Georgia, in response to urgent appeals by the community and San Juan County Commissioners. Dr. Brooks graduated from Bowman Gray and was a member of the Carbon County Medical Society.



PROCEEDINGS

of the

HOUSE OF DELEGATES

MONTANA MEDICAL ASSOCIATION

Ninth Interim Session

March 17, 1956

HELENA

The 9th Interim Session of the House of Delegates of the Montana Medical Association was called to order by George W. Setzer, M.D., President, at 8:45 a.m. in the Ballroom of the Placer Hotel, Helena.

Following the roll call of delegates, the Secretary, T. R. Vye, M.D., announced that all delegates seated had presented proper credentials and that a quorum was present.

It was regularly moved, seconded and carried that the reading of the minutes of the 77th Annual Meeting held in Bozeman, September 15-17, 1955, be dispensed with inasmuch as these minutes were published in the January, 1956, issue of the Rocky Mountain Medical Journal. It was then moved that the minutes of the Annual Meeting held in Bozeman, September 15-17, 1955, be approved as published in the Rocky Mountain Medical Journal. This motion was seconded and carried.

Raymond F. Peterson, M.D., delegate to the American Medical Association, reported at length upon the actions of the House of Delegates of that Association at its meeting in Boston, Massachusetts. The report of the delegate was referred by President Setzer to Reference Committee C for study.

Secretary's Report

T. R. Vye, M.D., read the following report of the Secretary-Treasurer which was referred to Reference Committee B by President Setzer for study:

Under the By-Laws of your Association your elected Secretary is responsible for the operation of the Executive Office. He is charged with many details and duties but fortunately is authorized, under the By-Laws, to delegate many of these to the Executive Secretary. Your present Secretary does delegate many of his duties but is in constant contact and available for consultation with the Executive Secretary on scientific or professional questions and on questions of policy. He is, therefore, quite familiar with all of the activities of the Executive Office and its employed staff. The work of this staff is constantly increasing but that, of course, is as it should be for your Association is a service group. Because it is a service organization, many of its benefits are intangible and are, therefore, not often understood by many of the members. As your Secretary, however, I can assure you that our Executive Office does perform many duties and participates in many activities of direct benefit to the profession as a whole and in many instances to the individual member. Your Executive Office is anxious to assist in every possible way not only the medical profession but also each of the individual members of the Association. I would like to take this opportunity, therefore, to suggest that you utilize its services whenever possible or necessary. Sometimes specific information upon your inquiry may not be immediately available but I am sure that the personnel of the Executive Office will know where to find the answer and will do so as expeditiously as possible.

One of the duties of your Executive Office, of course, is to reply to the many inquiries that are received daily and to attend to correspondence addressed to your Association and frequently to many of its officers. While neither your Secretary nor the Executive Secretary have attempted to keep an accurate record of either the incoming or the outgoing mail, I venture to estimate that your office receives over 700 pieces of mail each month and that its outgoing mail exceeds 1,200 pieces each month.

Through the monthly Bulletin that is mailed to all Montana physicians, your officers attempt to inform each of you of the important happenings in the economics of medicine both on a national and on a state level. We also endeavor to include news of Montana physicians as well as of the various component and specialty societies. I sincerely hope that every Montana physician reads his Bulletin carefully each month and that, as a result of the information contained in it, he will accept his responsibility and assist organized medicine in the promotion of its public relations and in opposing or supporting, as the case may be, legislation, either national or state, that is of interest to the medical profession.

Since 1950 there has been a constant increase in the number of active members in your Association. As of December 31, 1950, there were 446 active members in your Association. As of December 31, 1955, there were 503 active members or an increase of 13 per cent during this six-year period. During the same period the population of Montana has risen from approximately 587,000 to about 633,000 or an increase of nearly 8 per cent. The increase in the membership of your Association during the last year has been the greatest. Between the end of 1954 and the end of 1955 membership in your Association increased from 472 active members to 502 or about 6½ per cent. During the last few years there has also been a noticeable increase in the number of medical specialists who have established their practice in many of our communities of more moderate size.

As has been customary, your Secretary and your Executive Secretary attended the Clinical Session of the American Medical Association last December along with your delegate, R. F. Peterson, M.D., and your alternate delegate, Paul J. Gans, M.D. It is always extremely interesting to observe the operation and activities of the House of Delegates of the American Medical Association. It is a truly democratic body that acts in accordance with the wishes of the majority who are selected by you, the individual member of your state association and the American Medical Association. It is also gratifying to observe the recognition that is granted by the officers and other delegates of the American Medical Association to your own delegate and the other representatives of your state association at these meetings. May I take this opportunity to remind you that the next Clinical Session of the American Medical Association will be held in Seattle, Washington, November 27-30. I would like to urge that as many members of this Association as possible plan to attend this meeting, not only for its scientific value but also to take advantage of the opportunity of observing its House of Delegates in session. All members are very welcome at meetings of the House and I am sure that anyone who attends will enjoy it thoroughly.

With the approval of the Executive Committee of your Association, your Executive Secretary was requested to attend a meeting of the executive secretaries of all state and county associations in Chicago early in February. He was also requested to attend a professional relations meeting of the Blue Shield Commission shortly afterwards. The meeting of the executive secretaries offered an exceptionally fine program including a review of the work of a medical society executive, his relationship with physicians, the specialty societies and boards, relationships with allied professions, committee organization, procedures, publications, legal problems of medical associations, principles of management in association work, parliamentary procedure, etc. Your Executive Secretary was very grateful for the opportunity to attend this refresher course and I am sure benefited from his attend-

ance. The meeting was enthusiastically endorsed by the American Medical Association and both its president and secretary were gratified with the accomplishments.

Your Executive Committee, during January, also agreed to adopt the budget of income and expenses prepared by your Treasurer. Under this budget it is anticipated that the income of the Association during 1956 will exceed expenditures by $1,000.00 or more. It was estimated that the total income of the Association for the year 1956 will be about $29,800.00. Of this total income, approximately $26,000.00 will be received as dues for membership, $2,500.00 from the sale of exhibit space and the balance from interest on investments and other miscellaneous income. The total expenses of the Association for the current year, it is anticipated, will be about $28,500.00. The major expenses of the Association for the current year will include the following:

Operation of central office including salaries, taxes, rent, telephone and telegraph	$13,277.00
Meeting expenses	2,800.00
Stationery, supplies and postage	1,125.00
Officers and committee expenses	3,300.00
Executive Secretary travel expenses	2,500.00
Legal and accounting	660.00
Subscriptions, Rocky Mountain Medical Journal	1,225.00
Membership, Public Health League	1,470.00
Woman's Auxiliary Budget	1,325.00
Contributions and dues	350.00
Miscellaneous expenses	375.00
Total	$28,407.00

Last year, with the approval of this House of Delegates, a system of reference committees was initiated to study in advance the reports of the various standing and special committees of this Association and to recommend action upon each of these reports to this House. Your Secretary, as well as your delegate and alternate delegate to the American Medical Association, have observed this system in operation at many A.M.A. House of Delegates meetings and are convinced that the use of such reference committees offers not only a democratic but an efficient method of review of committee reports and recommendations. As each of you, as delegates, become more familiar with this method, I am sure that you will better understand and appreciate its effectiveness.

To facilitate the understanding of the reports of the reference committees and of their discussion of any particular committee report, your Executive Office has for the first time prepared copies of all committee reports filed in advance for each delegate. I would like to suggest that each delegate present turn to the appropriate committee report and review it as each reference committee chairman discusses the recommendations of his committee upon the particular report.

The reports in your file are only those that were submitted to the Executive Office in advance of this meeting. No doubt a number of additional committee reports will be received and referred to the reference committees so that the recommendations in them may be acted upon by this House. I am sorry that more committee reports were not filed in advance so that the Executive Office would have had an opportunity to duplicate all of them for you.

If you like the idea of having a copy of the report of each of the standing and special committees available as it is discussed by the chairman of the reference committee, your Executive Office will try to continue this system. To make it truly effective, however, the chairman of every standing and special committee of this Association must be urged to submit the report of his committee to the Executive Office at least two weeks in advance of any meeting of this House.

Executive Committee Report

T. R. Vye, M.D., Secretary, read the following report of the Executive Committee, which was referred to Reference Committee B by President Setzer for study:

Since the last Annual Meeting of the House of Delegates in Bozeman during September, 1955, your Executive Committee has met on four occasions to consider various items of business of the Association.

At the first of these meetings, the Executive Committee appointed, in cooperation with President Setzer, the personnel to all standing and special committees for the current administrative year. Most of these committees, in our opinion, have functioned extremely well during the first six months of this administration and are to be commended for their accomplishments.

At a meeting of the Executive Committee on November 19, 1955, James M. Flinn, M.D., a past president of this Association, was reappointed to represent the medical profession on the Board of Directors of the Public Health League of Montana for a three-year term. Since his reappointment, Dr. Flinn was also re-elected President of the League. Your Executive Committee also voted to hold the 1956 Annual Meeting of the Association in Great Falls on Thursday, Friday and Saturday, September 13-15, 1956, and approved a proposal of the Cascade County Medical Society that this Annual Meeting be combined with the regular Medical-Surgical Conference sponsored by that component society during June of each year. It was the opinion of the Executive Committee and of the members of the Cascade County Medical Society that, as a result of the cooperative efforts of both groups in planning and financing the 1956 Annual Meeting, a better meeting may be organized and that our Program Committee would be able to select more outstanding clinicians to participate in the scientific sessions with less restriction.

At another meeting of the Executive Committee on January 21, 1956, a resolution from the Lewis and Clark County Medical Society, requesting that President Setzer appoint an impartial committee to study certain aspects of Montana Physicians' Service and the income levels of its service program, was carefully reviewed and discussed. At this meeting the Executive Committee empowered President Setzer to appoint this special committee as requested and confirmed his selection of the following to serve as members of the special committee: Paul J. Gans, M.D., Lewistown, Chairman; Edward W. Gibbs, M.D., Billings; William F. Morrison, M.D., Missoula; Duncan S. MacKenzie, Jr., M.D., Havre; A. K. Atkinson, M.D., Great Falls; Harold W. Gregg, M.D., Butte; and George E. Trobough, M.D., Anaconda. Since this action, similar resolutions have been received from two other component societies.

At the request of the American Medical Association, the Executive Committee agreed to select a Montana physician to serve as its representative on the Program Committee for the A.M.A. Clinical Session which will be held in Seattle, November 27-30, 1956. The Executive Committee adopted the suggestion of President Setzer that John A. Layne, M.D., be appointed to this office and that it be his duty as our representative on the Program Committee to encourage as many Montana physicians as possible to participate in the scientific program and exhibit section of this A.M.A. meeting.

At the Annual Meeting of the House of Delegates in Bozeman, it was voted that the Executive Committee determine the advisability of authorizing a representative of this Association to attend the annual Conference on Mental Hygiene and the annual Public Relations Conference, both of which are sponsored by the American Medical Association. It was voted by the Executive Committee that the Association reimburse representatives of these committees for their first-class travel expenses to these meetings if the attendance of a representative was deemed to be of value to the Association and if the representative was prepared to submit a full and complete report to stimulate future activities of the committee.

The Executive Committee considered a suggestion received by the chairman of the Legislative Committee from the Secretary of the Silver Bow County Medical Society that appropriate amendments to the laws of this State be introduced at the next session of the Legislature to provide an increase in the fees for testimony of a physician in commitment proceedings of the insane to the State Hospital. The Executive Committee agreed that this fee should be increased but suggested that perhaps the appropriate laws could be rewritten so that a specific fee was not stated in the law but that the amount of the fee may be determined by the courts. The committee also suggested that these amendments to the law may be more favorably considered by the Legislature if they were presented and endorsed by the Montana Bar Association. These suggestions were referred by the Executive Committee to the Legislative Committee of this Association for action.

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T. R. Vye, M.D., Secretary, then read the following supplemental report of the Executive Committee which was referred for study to Reference Committee C by President Setzer:

Supplemental Report

At the meeting of the Executive Committee in Helena on January 21, 1956, the various proposals to amend the By-Laws of the Association which were submitted at the Annual Meeting of the House of Delegates in Bozeman were reviewed. It was agreed by the Executive Committee that the following comments and recommendations of the committee be reported to the House at its Interim Session for its information: (1) that the Executive Committee recommend to the House of Delegates the adoption of the proposed amendment to provide that the Committee on Mental Hygiene become a standing committee of this Association; (2) that the proposal to amend the By-Laws to revise the name of the Legal Affairs and Malpractice Committee be tabled until a more appropriate and descriptive name for the committee is suggested; (3) that the proposal to increase the annual membership dues in this Association $15.00 per year be submitted to this House of Delegates for consideration without recommendation from the Executive Committee; (during the discussion of this proposal it was pointed out that a similar proposal has been referred to the Board of Trustees of the American Medical Association by its House of Delegates and that no action will be taken by the Board of Trustees or the House of Delegates of the American Medical Association until its Annual Meeting in Chicago during June. The Executive Committee, however, agreed during its discussion of this proposal to recommend to the Resolutions Committee of this Association that it draft a resolution for presentation to the House of Delegates at its Interim Session opposing any increase in dues for membership in the American Medical Association to provide compulsory contributions to the American Medical Education Foundation); (4) that the proposed amendments to provide a Speaker and Vice Speaker of the House of Delegates be rereferred to this House for action without opinion or recommendation by the Executive Committee. The Executive Committee, however, did agree that if the proposed amendments are adopted by this House the wording of the last two sentences of the proposed amendment to Section 8 of Article IX be revised to read, "He shall have all the power of a presiding officer in the appointment of committees **only** for the conduct of business of the House of Delegates **while currently assembled,** as well as such other duties as may rest within the jurisdiction of the presiding officer to facilitate the legislative activities of the House of Delegates **in session.** The duties of the Speaker shall not in any way conflict with the rights, duties and privileges of the President **who shall appoint all standing and special committees of this Association."** (Words in bold type indicate suggested revision.) This revision in the wording of this proposed amendment is suggested by the Executive Committee for clarification. It is the opinion of the Executive Committee that if these proposals to amend the By-Laws and provide a Speaker and Vice Speaker are adopted, the revision in the wording suggested above may be approved also without awaiting the next meeting of the House, since the proposals do not change the intent of the amendment but merely clarify it.

George M. Donich, M.D., on behalf of the Auditing Committee, reported that the books of the account of the Association for the year 1955 were in order and accurately reflected its financial transactions. This report was ordered placed on file by President Setzer.

James M. Flinn, M.D., Chairman of the Resolutions Committee, introduced resolutions upon the following subjects for the consideration of the House of Delegates:

Resolutions

1. Opposing the increase in membership dues to support American Medical Education Foundation;
2. Appreciation to the Legislative Assembly for its support of the Western Regional Education Compact;
3. Appreciation to M. Shelby Jared, M.D., Montana Physicians' Service, Professor John Lester and the music students from Montana State University, the Montana Division of the American Cancer Society and Gertrude L. Pease, M.D., the Lewis and Clark Medical Society and its Auxiliary, the Veterans Administration Hospital, the Program Committee, the Helena newspaper and radio stations and the Placer Hotel.

H. M. Clemmons, M.D., presented a resolution endorsing the principle of fluoridation of community water supplies in Montana. V. D. Standish, M.D., presented a resolution about the fees for administration of Salk vaccine obtained through commercial channels and through public sponsored programs. All of the resolutions were referred to Reference Committee C for study by President Setzer.

W. A. Treat, M.D., moved that S. C. Pratt, M.D., be seated as a delegate from the Southeastern Montana Medical Society. This motion was seconded and carried. A. R. Kintner, M.D., moved that E. J. Drouillard, M.D., be seated as a delegate from the Western Montana Medical Society. This motion was seconded and carried.

Montana Physicians' Service

Paul J. Gans, M.D., Chairman of the special committee to study Montana Physicians' Service, read the following report:

This committee was appointed in February, 1956, by President Setzer at the request of the Lewis and Clark Medical Society. The committee held its first meeting with all members present except one at Fort Harrison on March 16, 1956.

A discussion of the purposes of the committee and the problems to be investigated was held. A program for continued study was discussed and the committee agreed to hold another meeting at which members of the Montana Medical Association wishing to appear and voice opinions concerning Montana Physicians' Service would be invited. It is the request of this special committee that as many members as possible plan to be present at this meeting and that those who are unable to attend present their criticisms, views and suggestions to the committee in writing, as far in advance as possible. The committee would like to hear not only from those dissatisfied with the present program but also from those who approve of it.

Unless otherwise notified, the next meeting of this special committee will be held at the Placer Hotel, Helena, on May 12 and 13, 1956. Further information about the meeting will be published in the Bulletin of the Association.

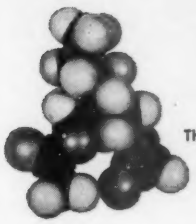
This special committee recommends that any anticipated action by this House of Delegates which would affect the present operation of Montana Physicians' Service be withheld until such time as this committee has had an opportunity to fully investigate the present complaints. The committee further recommends that in the future any changes which will affect the operation of Montana Physicians' Service be referred to the House of Delegates of the Montana Medical Association for consideration before such changes become operative.

It was moved by W. F. Cashmore, M.D., and seconded that action upon this report of this special committee be deferred. Following a brief discussion, however, a substitute motion was offered that the report of this special committee be referred to Reference Committee C for study. This motion was seconded and carried.

Reference Committee "A"

The following report was presented by F. D. Hurd, M.D., Chairman of Reference Committee A:

Reference Committee A was responsible for the study of the reports of the various scientific committees of this Association.



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The Cancer Committee under the chairmanship of H. H. James, M.D., reported upon the Cancer Registry maintained in cooperation with the State Board of Health. Because of the extreme confidentiality of this Registry, follow-up becomes extremely difficult since the necessary information may be obtained only through physicians' reports and death certificates. At present the chief value of the Register is statistical and, as such, is of value to physicians in evaluating treatment. It is useful in comparing death and cure rates, not only in Montana, but also in other states. It is the recommendation of the Cancer Committee that physicians throughout Montana cooperate with the State Board of Health in reporting information about cancer patients so that the Register may be continued and may be of value to the medical profession. It was also the recommendation of the Cancer Committee that this House of Delegates urge all component societies of the Montana Medical Association to actively cooperate with local cancer societies in all of their educational services. Your Reference Committee concurs in these recommendations.

Dr. Hurd moved approval of this portion of the report of the Reference Committee. This motion was seconded and carried.

The Tuberculosis Committee, under the acting chairmanship of Harry W. Power, M.D., recommends the establishment of a skin testing program through the school systems within the State of Montana in cooperation with the Montana Tuberculosis Association and the Montana Trudeau Society and that if such a program is approved by this House of Delegates, these organizations will develop final details to conduct the program throughout the State. The Tuberculosis Committee also discussed the need of legislation in Montana to regulate the recalcitrant tuberculous patient. For the information of this House of Delegates, the Tuberculosis Committee suggests that the following statement of policy be referred to the Legislative Committee of this Association for its consideration and action: The policy of the State of Montana states that all cases of tuberculosis in a communicable stage must be isolated in an approved hospital, institution, nursing home, or at the home of the patient if such isolation meets the approval of the local health physician. Refusal of the tuberculous patient to carry out one of these methods of isolation when he is endangering the health of the general public or his family must be construed as an abnormal mental process. Because of the danger to the health of the general public or family, this person, unless he accepts the recommendation of the local health officer, should be committed to the Tuberculosis Division of the Montana State Mental Hospital for the duration of time his disease is communicable. If, after approved methods of treatment, the patient should desire to transfer to the regular State Sanitarium and if his mental status has improved to that point, he could voluntarily relieve himself from the mental institution and be transferred to Galen. The usual commitment procedures required for entrance into the mental hospital would have to be carried out to safeguard the inalienable rights of the individual. Your Reference Committee concurs in these proposals and recommends their approval by this House of Delegates.

Dr. Hurd moved the adoption of this portion of the Reference Committee report. This motion was seconded and carried.

The Fracture and Orthopedic Committee, under the chairmanship of Charles F. Honeycutt, M.D., reports that: The program to provide orthopedic consultation service at the Montana State Tuberculosis Sanitarium by qualified orthopedic surgeons was approved at the 77th Annual Meeting of the House of Delegates. The actual mechanics of such a consultation service are being worked out and will probably be concluded favorably at the committee meeting during this Interim Session. Arrangements have been made to have a joint meeting between Frank Terrill, M.D., the Tuberculosis Committee and the Fracture and Orthopedic Committee of the Montana Medical Association during the Interim Session to accomplish this. It is mandatory at this time that the plan to reduce hospital expenses incurred for child health services by transfer to convalescent hospital facilities at Shodair Hospital for long term cases be consummated. The State Board of Health does not have sufficient funds because of the default of federal appropriations to continue without this plan being immediately put into operation. This plan is to hospitalize, for convalescent care, children who need hospitalization for longer than one month. If such a child needs further surgery or examination by the physician originally caring for the child, then the child will be returned to the hospital and to the physician. This situation will probably not arise in very many cases, as the Division of Child Health Services has been able to secure foster home care or return the child to the family until such time as further medical attention is necessary. It will not be possible to transfer a child from any hospital in another town if the child needs continuous care by the physician who initiated this care. The Division of Child Health Services of the State Board of Health is putting this plan into effect due to the urgency of the situation and respectfully requests the approval of this plan by the House of Delegates. Your Reference Committee recommends the adoption of these proposals of the Fracture and Orthopedic Committee.

Dr. Hurd moved the adoption of this portion of the Reference Committee report. This motion was seconded and carried.

Your Reference Committee carefully reviewed the reports of the Committee on Blood, under the chairmanship of John A. Newman, M.D., and of the Rheumatic Fever and Heart Committee under the chairmanship of John Gilson, M.D. Since neither of these reports contained a request for action or recommendations for the consideration of this House, your Reference Committee suggests only that they be placed on file.

Dr. Hurd moved the adoption of this portion of the report. This motion was seconded and carried.

The report of the Maternal and Child Welfare Committee under the chairmanship of Chester W. Lawson, M.D., included the following recommendations which have been carefully reviewed by your Reference Committee: (1) that frequent announcements urging Montana physicians to furnish the information requested in the fetal and neonatal death questionnaires be included periodically in the Bulletin; (2) that the President of the Association be requested to appoint two additional members to the Pediatric Sub-Committee so that each of the major cities in the State will be represented upon it; (3) that the Chairman of the Program Committee of this Association be urged to favor the inclusion of an address by a member of the Maternal and Child Welfare Committee on the scientific program of each Interim Session upon the subject of perinatal and maternal deaths; (4) that in view of the increased proportion of mortality due to prematurity, this committee urges the State Board of Health to increase its staff so that it will be able to send a team of qualified instructors to all areas of the State to teach nurses in the care of prematures, set standards for premature nurseries and supervise premature care in hospitals and that the committee recommend to the House of Delegates that it endeavor to obtain the appropriation of additional funds by the next Legislature so that the Board may increase its staff to establish this program. It is the opinion of your Reference Committee that the first three recommendations of this committee, as outlined above, need not be acted upon by this House, but merely referred to the appropriate committee or officer for consideration. Your Reference Committee also believes that the recommendation of the Maternal and Child Welfare Committee to support an increased appropriation for the State Board of Health should be deferred for further consideration and study along with the other budgetary requests of the State Board of Health.

Dr. Hurd moved the adoption of this portion of the Reference Committee report. The motion was seconded and carried.

The report of the Polio Advisory Committee, under the chairmanship of C. W. Pemberton, M.D., included the following recommendations which were carefully reviewed by your Reference Committee: (1) that the polio vaccine program now in operation continue essentially as it is with the amount of vaccine available being distributed in approximately equal amounts between commercial channels and the federally financed programs; (2) that this Association and the Montana Pharmaceutical Association again remind their members of the desirability and necessity of completing the necessary reports for the State Board of Health in order to provide equitable distribution of polio vaccine and to maintain proper relationships in the polio

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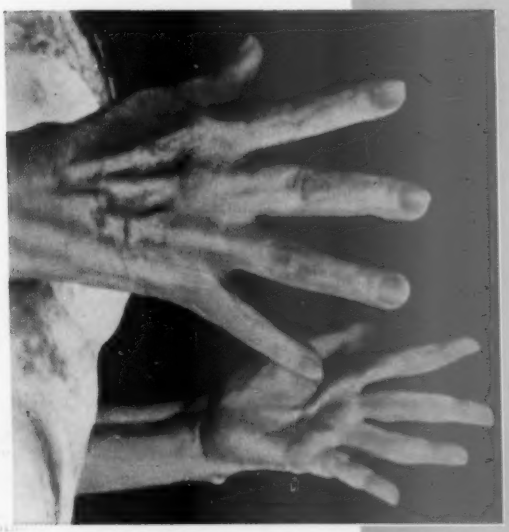
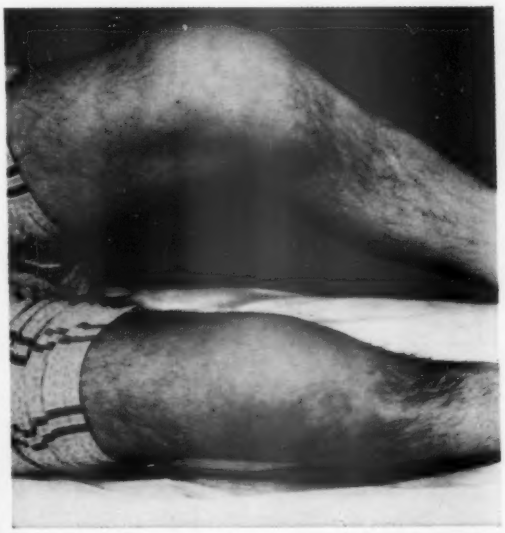
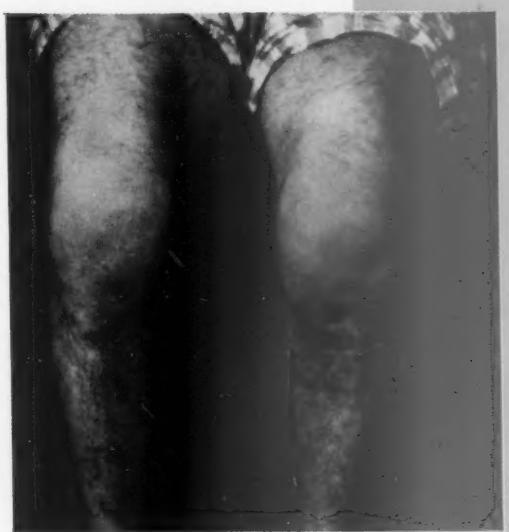


After two weeks on METICORTEN, *patient is free of pain and can open hands completely.*



Acutely swollen, painful knees in man with rheumatoid arthritis before therapy.



After two weeks on METICORTEN, *swelling of knees is gone and patient can walk without difficulty.*

in corticosteroid therapy permits treatment of more patients

- rarely causes edema or electrolyte side actions
- 3 to 5 times more potent, milligram for milligram, than hydrocortisone or cortisone
- excellent relief of pain, swelling, tenderness; diminished joint stiffness—in rheumatoid arthritis
- excellent relief of bronchospasm, dyspnea, cough; increased vital capacity in asthma
- hormone benefits in respiratory allergies, inflammatory and allergic eye and skin disorders, collagen diseases

METICORTEN is available in 1 mg., 2.5 mg. and 5 mg. white tablets, and as 2.5 mg. and 5 mg. capsules.
METICORTEN,* brand of prednisone. MC-J-614-586 *T.M.

vaccine voluntary control program; (3) and that the program of the State Board of Health for distribution of gamma globulin for measles and infectious hepatitis continue as it is presently operated except that (a) the use of gamma globulin be limited to one dose; (b) the use of gamma globulin for infectious hepatitis be limited to the following groups in the order named: pregnant women, adults 18 and over, children under 3 years of age, other children 3 years through 17 years of age. Your Reference Committee concurs in each of these recommendations and recommends their approval by this House of Delegates.

Dr. Hurd moved the adoption of this portion of the Reference Committee report. This motion was seconded and carried.

Dr. Hurd, as Chairman of Reference Committee A, expressed his sincere appreciation to the members of his Reference Committee and to the chairmen of all of the standing committees of this Association for their cooperation and assistance. He then moved the adoption of the report of Reference Committee A as a whole. This motion was seconded and carried.

It was moved by A. R. Little, Jr., M.D., that the portion of the report of Reference Committee A upon the first recommendation of the Polio Advisory Committee about the distribution of polio vaccine be reconsidered. This motion was seconded and carried. Following the approval of this motion, the polio vaccine program and the proportion of the vaccine allocated to federally sponsored programs and to commercial channels was discussed and explained by Raymond F. Peterson, M.D., delegate to the American Medical Association, and G. D. Carlyle Thompson, M.D., Executive Officer of the State Board of Health. Following this explanation, it was moved by A. R. Kintner, M.D., that this portion of the report of the Polio Advisory Committee be referred to Reference Committee C for consideration in conjunction with the resolution upon this subject which was referred to this committee earlier. This motion was seconded and carried.

Reference Committee "B"

The following report was presented by Paul J. Gans, M.D., on behalf of George D. Waller, M.D., Chairman of Reference Committee B:

Reference Committee B, which was responsible for the study of the reports of the various business committees and officers of this Association, is pleased to advise the members of this House of Delegates that the chairman of all of these committees except three prepared and submitted written reports of their activities since the 1955 Annual Session. The reports of the following committees and of the Secretary were informational and contained no requests for action and no recommendations for the consideration of this House of Delegates: Executive Committee, Program Committee, Committee on Medical-Legal Institute. Your committee commends the chairman of each of these committees and the Secretary-Treasurer for their informative reports.

It was moved by Dr. Gans that this portion of the report of Reference Committee B be adopted. This motion was seconded and carried.

The report of the Economic Committee, under the chairmanship of Leonard W. Brewer, M.D., recommended that this House of Delegates urge the inclusion of the following fees for orthopedic services in the Fee Schedule of the Industrial Accident Board:

Partial laminectomy and spine fusion	$350.00
Arthrodesis or arthroplasty hip, knee or shoulder	250.00
Arthrodesis ankle, elbow or wrist	200.00
Triple arthrodesis (inc. subastragalar and midplantar joints)	200.00
Repair torn musculotendinous cuff shoulder	200.00
Repair for recurrent dislocation shoulder	200.00
Removal semilunar cartilage (meniscus) knee	150.00

The Economic Committee in its report also recommended the deletion of the following item, No. 3909, from the Average Fee Schedule of this Association since it is of no value in its present form: Innoculations, injections and immunizations, except that drugs, when expensive, will be additional, $12.00. Your Reference Committee concurs in these recommendations and suggests their approval.

Dr. Gans moved the approval of this portion of the report of Reference Committee B. This motion was seconded and carried.

The Committee on Necrology and History of Medicine, under the chairmanship of L. W. Brewer, M.D., reported the death of the following physicians since the last meeting of this House of Delegates:

Gordon Merriam, M.D., Fairview, October 6, 1955

Harve A. Stanschfield, M.D., Dillon, January 9, 1956.

Your Reference Committee suggests that the report of the Committee on Necrology and History of Medicine be placed on file.

Members of the House of Delegates stood for a moment of silence in memory of these deceased physicians.

Dr. Gans moved the adoption of this portion of the report of Reference Committee B. This motion was seconded and carried.

The report of the Public Relations Committee, under the chairmanship of C. R. Svore, M.D., was reviewed by your Reference Committee with much interest. The Public Relations Committee, in its report, recommended that all Montana physicians subscribe to the health education journal, "Today's Health," published by the American Medical Association and that they place it in their reception rooms; that all physicians be urged to frankly discuss their fees for medical and surgical services with their patients and that the plaque distributed by the American Medical Association entitled, "To all my Patients," be prominently displayed in the office of all Montana physicians; that the certificate of membership in the Montana Medical Association be prominently displayed in the office of all Montana physicians. Your Reference Committee concurs in these proposals of the Public Relations Committee and recommends their approval by this House of Delegates.

Dr. Gans moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

The report of the Legal Affairs and Malpractice Committee under the chairmanship of Park W. Willis, Jr., M.D., was reviewed with interest by your Reference Committee. This standing committee has prepared the following statement of its purposes and of the scope of its activities: The sphere of activity of the committee shall be limited to medico-legal affairs which affect members of the Association but not those of the Association itself. Its purposes shall be as follows: (1) To advise on request and when necessary institute an impartial investigation of the relevant facts whenever malpractice action is threatened or instituted against any member of the Association. The Committee shall confer with the defendant physician, his attorney and the legal representative of the insurance carrier, advising as to whether the case should be settled or defended. When the case is to be settled, the committee shall advise as to what is fair and just and shall participate in the resistance of unreasonable demands. When the case is to be defended, the committee shall assist in evaluation of the pertinent medical facts to be used in preparation of the defense and shall aid in the selection of physicians for defense testimony. (2) To investigate and, if advisable, refer to the Council of the Association, actions taken by a member or any committee or group of physicians which directly or indirectly lead to institution of malpractice suit against any physician member of the Association. (3) To study and formulate an opinion on the nature of any medical testimony given in court by any member of the Association if that member is charged with, or suspected of, unfair, unreasonable or unjust testimony, and shall prefer charges before the Censorship Committee of the member's component society or the Council of the Montana Medical Association if censorship is indicated. (4) To formulate a body of rules by which the committee shall be governed in carrying out its assigned functions.

for the acutely agitated...

QUIESCENCE AND EMOTIONAL DETACHMENT

NEW Potent Ataraxic

Sparine*

HYDROCHLORIDE

Promazine Hydrochloride

10-(γ-dimethylamino-*n*-propyl)-phenothiazine hydrochloride

INDICATIONS:

- The acute alcoholic[1,2]—delirium tremens, acute hallucinosis, tremulousness
- The acute psychotic[1]—acute excitation due to various psychoses
- The drug addict[1]—withdrawal syndrome: nausea, vomiting, muscle and bone pains, abdominal cramps, general malaise

FINDINGS:

"The drug . . . is effective in . . . maintaining these subjects in a quiescent detached state. . . . Complications such as jaundice, . . . dermatitis, edema, lactation, basal ganglion disturbances, or depression were not observed during these studies."[1]

As with any new and potent agent, it is well to be fully informed on the precautions of use and the possibility of side-effects. Before prescribing SPARINE, the physician should consult the direction circular.

For intravenous, intramuscular, or oral administration.

Supplied: Tablets, 25, 50, and 100 mg., bottles of 50 and 500; 200 mg., bottles of 500. Injection, 50 mg. per cc., vials of 2 and 10 cc.

1. Fazekas, J.F., et al.: J.A.M.A. **161**:46 (May 5) 1956. 2. Mitchell, E.H.: J.A.M.A. **161**:44 (May 5) 1956.

*Trademark

Wyeth

Philadelphia 1, Pa.

An Exclusive Development of Wyeth Pharmacological Research

Such rules may be modified or adopted by the Executive Committee of the Montana Medical Association and if approved by the House of Delegates of the Association shall be binding on all members of the Association. (5) To assist upon request, but at its own discretion, any physician not a member of the Montana Medical Association. (6) To cooperate with the Mediation Committee, the Public Relations Committee and other committees of the Montana Medical Association regarding the rights of the public in bettering its welfare. (7) To cooperate with the Montana Bar Association or its component societies in medico-legal matters, including complaints or charges of unethical conduct. This standing committee has also proposed the following rules for the operation of the committee and for the guidance of individual members of this Association: (1) The Legal Affairs Committee of the Montana Medical Associaton shall meet at such times and places as are deemed necessary by the Chairman to discharge its duties satisfactorily. (2) Decisions arrived at by any five (5) members of the Legal Affairs Committee shall be considered the expression of the entire committee. (3) In carrying out its assigned functions, the committee shall be authorized to secure the aid of any physician member of the Association to give expert medical advice or expert medical testimony and to assist the committee in other ways as may be required. (4) To be eligible for assistance by the committee, a physician member of the Association must have complied with the Constitution and By-Laws of the Montana Medical Association and with the rules of the Legal Affairs Committee. (5) Any physician member of the Association against whom malpractice action is threatened or instituted shall within fourteen (14) days of such date notifv the Chairman of the Legal Affairs Committee in writing, either directly or through the Executive Secretary of the Association. Such notice shall include a copy of the complaint, if available, the names and addresses of the plaintiff and his attorney, the name of the defendant's insurance carrier and whether the carrier has been notified of threatened or actual suit, and an estimate of the status of the case at the time of notification. Failure of a member to render such notice within the period specified without adequate reason may be cause to deprive him of the assistance of the Legal Affairs Committee. (6) It shall be the duty of any member of the Association to notify the Chairman of the Legal Affairs Committee directly or through the Executive Secretary of the Association whenever he becomes aware that a malpractice action is threatened or impending against any other member of the Association or whenever he becomes aware of any violation of the rules of the Legal Affairs Committee. (7) It shall be the duty of any physician member of the Association to inform the committee of his intent and reasons whenever he is to testify in any malpractice action against a member of the Association. In this connection it is to be understood as a matter of policy of the Association and its Legal Affairs Committee that the welfare of the patient is paramount and that any physician shall have the right to testify as he in conscience considers right and just. It shall also be understood that payment to physicians for testimony in malpractice actions shall be subject to review and approval by the committee. (8) The decision of the Legal Affairs Committee shall be final as to whether the defense shall be supported in any malpractice action. (9) No physician member of the Association shall agree to settle any malpractice claim against him without prior consent of the committee, except upon advice of his insurance carrier. In such cases of settlement, the committee is to be notified as to disposition of the suit. (10) It shall be the policy of the committee, whenever investigation indicates that medico-legal action against a member of the Association has been precipitated or influenced by unfair and unjust criticism of another physician, to refer the findings and facts to the appropriate censorship committee or the Council of the Montana Medical Association. (11) The Legal Affairs Committee will not aid in the defense of any criminal action nor in any other action if the committee, after investigation, has reason to believe that a criminal act is involved or that the member being sued has not conformed to the recognized ethics of the profession. (12) The Chairman may disqualify any member of the Legal Affairs Committee or any member may disqualify himself whenever it appears that his presence would be prejudicial to either party of the action. (13) In cases referred initially to the Legal Affairs Committee which subsequently result in no legal action, the committee may at its discretion refer the matter to the Mediation Committee of the Montana Medical Association. (14) The Legal Affairs Committee may at its discretion request from the President of the Montana Medical Association a replacement for any member of the Committee who is absent repeatedly from the committee meetings without adequate reason. Your Reference Committee concurs wholeheartedly in the purposes and rules as proposed by this standing committee and recommends their adoption by this House of Delegates.

Dr. Gans moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

H. M. Clemmons, M.D., moved that a copy of the purposes and scope of the activities of the Legal Affairs Committee and of its rules be mailed to each Montana physician. This motion was seconded and carried.

The Mediation Committee under the chairmanship of Harold W. Fuller, M.D., in its report recommended that the Secretary of the Montana Medical Association be requested to communicate with the proper officers of the Montana Hospital Association to request that it encourage all hospitals in Montana to permit the Mediation Committee to examine hospital records when necessary and that it make every effort to instruct nurses and physicians to maintain adequate and accurate notes in the hospital records. Your Reference Committee heartily concurs in these proposals and recommends their approval by this House of Delegates.

Dr. Gans moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

The report of the Medical Emergency Committee under the chairmanship of George E. Trobough, M.D., outlined in detail the many important activities of this committee and recommended that the House of Delegates of this Association approve the use of dog tags as the best means of identification of school children for purposes of civil defense and that the other recommendations of this committee, as approved by this House of Delegates at previous meetings, be reaffirmed. Your Reference Committee concurs in these recommendations and recommends their approval.

Dr. Gans moved the adoption of this portion of the report of the Reference Committee.

Dr. Gans then expressed the appreciation of the members of Reference Committee B to the chairman and members of each of the reporting committees for their cooperation. He moved the adoption of the report of Reference Committee B as a whole.

A. W. Axley, M.D., moved that Robert H. Leeds, M.D., be appointed as a delegate from the Hill County Medical Society. This motion was seconded and carried.

Reference Committee "C"

The following report was presented by M. A. Gold, M.D., Chairman of Reference Committee C:

This committee was responsible for the review of the reports of the Resolutions Committee, of certain special committees and of representatives of this Association to other state and national organizations.

The members of Reference Committee C especially wish to commend R. F. Peterson, M.D., delegate to the American Medical Association, for his very interesting and informative report and to endorse his suggestion that all Montana physicians plan to attend the 1956 Clinical Session of the American Medical Association in Seattle, November 27-30. We also wish to acknowledge with appreciation the informative reports that were submitted to this Reference Committee by S. D. Pratt, M.D., our representative on the Joint Commission for the Improvement of the Care of the Patient; by W. G. L. Tanglin, M.D., our representative on the Montana Health Planning Council; and Paul J. Gans, M.D., Montana representative to the American Medical Education Foundation. Since the reports of these representatives contain no requests for action or no recommendations for the consideration of this

House, your Reference Committee suggests that they be placed on file.

Dr. Gold moved that this portion of the report of the Reference Committee be adopted. This motion was seconded and carried.

John J. Malee, M.D., the Congressional Liaison representative of our Association to the Legislative Committee of the A.M.A., recommended in his report about national legislation that each component society of this Association appoint a committee to be responsible for informing all members of this Association in the component societies about national legislation and to suggest that each of these members immediately contact their representatives in Congress to inform them of the position of organized medicine upon any measure when necessary. Dr. Malee in his report also recommended that the medical profession be very determined in its opposition to HR 7225, a bill to amend the Social Security Act now being considered before the Finance Committee of the United States Senate. Your Reference Committee heartily endorses these proposals and recommends their adoption.

Dr. Gold moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

The supplemental report of the Executive Committee and the several recommendations included therein were reviewed with care. Your Reference Committee concurs in the recommendation of the Executive Committee that the By-Laws of this Association be amended so that the Committee on Mental Hygiene shall become a standing committee of this Association.

Dr. Gold moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

While the Executive Committee in its supplemental report recommended that the proposal to amend the By-Laws to revise the name of the Legal Affairs and Malpractice Committee be tabled until a more appropriate and descriptive name is suggested, your Reference Committee, after further conferences with the members of the Legal Affairs Committee and with other members of this Association, recommends that the By-Laws be amended to change the name of the Legal Affairs and Malpractice Committee to the Committee on Legal Affairs. In the opinion of your Reference Committee this proposal to amend the By-Laws may be acted upon finally by this House of Delegates at this session since all component societies were notified of the intention of the Legal Affairs and Malpractice Committee to recommend a revision in these By-Laws to change the committee name.

Dr. Gold moved the adoption of this portion of the report of the Reference Committee. This motion was seconded and carried.

Your Reference Committee has noted that the Executive Committee of this Association referred the proposal to increase the annual membership dues in the amount of $15.00 per year to this committee and to the House without recommendation. Your Reference Committee, however, is of the opinion that this proposal should be endorsed by the House of Delegates and recommends that the membership dues be increased $15.00 per year and that this amount be designated as a contribution to the American Medical Education Foundation.

Dr. Gold moved that this portion of the report of the Reference Committee be adopted and the motion was seconded. During the discussion of this motion, it was suggested that the proposal to increase the dues be modified so that those members who contribute $15.00 or more per year to medical schools will be exempt from the increase in dues. Following further brief discussion, the motion of Dr. Gold was voted upon, but it failed to carry. It was then regularly moved, seconded and carried that the proposal to increase the membership dues $15.00 per year be not adopted.

The supplemental report of the Executive Committee also transmitted, without recommendation, to this Reference Committee and this House the proposal to amend the By-Laws of the Association to provide a speaker and a vice-speaker of the House of Delegates. Your Reference Committee at the 1955 Annual Meeting of this House of Delegates recommended the adoption of the necessary amendments to the By-Laws to provide these offices. The committee is still of the same opinion and recommends the adoption of the various proposals to amend the By-Laws to provide a speaker and a vice-speaker.

Dr. Gold moved the adoption of this portion of the report of the Reference Committee. This motion was seconded, but after a lengthy discussion failed to carry by a vote of 16 to 23. It was then regularly moved, seconded and carried that the proposal to amend the By-Laws to provide a speaker and vice-speaker be not adopted.

Following the adoption of this motion, Dr. Gold requested permission to defer the presentation of the balance of the report of Reference Committee C until the House reconvened following luncheon. There being no objection, this permission was granted by President Setzer.

New Component Chartered

F. D. Hurd, M.D., read the following report of the Council of this Association:

The Council at its meeting on March 15 considered the petition of a group of physicians in Lake and Sanders Counties to form a new component society of this Association. Since the physicians and component societies concerned have complied with our By-Laws regulating the formation and organization of a new component society it is the recommendation of the Council that the House of Delegates authorize and approve the organization of this new society which is to be known as the Lake-Sander Counties Medical Society and that this House approve the issuance of a charter to it.

It was moved by Dr. Hurd that this report be adopted, that the House of Delegates authorize the organization of the Lake-Sanders Counties Medical Society and approve the issuance of a charter to it. This motion was seconded and carried.

President Setzer requested Harold W. Fuller, M.D., President of Montana Physicians' Service, to present his report for the information of the members of this House upon the activities of that organization as well as any proposals that it plans to submit to the Administrative Body for action. Since the proposals included in this report were for action by the Administrative Body, it was ordered placed on file by President Setzer.

This session of the House of Delegates then recessed at 12:15 p.m.

The second session of the 9th Interim Session of the House of Delegates reconvened in the Ballroom of the Placer Hotel at 1:30 p.m. Following the call to order by President Setzer, the Secretary, T. R. Vye, M.D., announced that a quorum was present.

It was moved by E. P. Higgins, M.D., that G. B. Wright, M.D., be seated as a delegate from Flathead County Medical Society. This motion was seconded and carried. It was then moved by George E. Trobough, M.D., that George M. Donich, M.D., be seated as a delegate from the Mount Powell Medical Society. This motion was seconded and carried.

Resolutions Adopted

M. A. Gold, M.D., Chairman of Reference Committee C, then continued the presentation of the report of his Reference Committee.

The following resolutions proposed by the Resolutions Committee have been carefully studied by your Reference Committee which recommends their adoption.

WHEREAS, the House of Delegates of American Medical Association has recommended to the Board of Trustees that consideration be given to an increase in the annual dues for all association members, said increase to be designated for contribution to the American Medical Education Foundation; and

WHEREAS, if the Board of Trustees of the American Medical Association should act favorably upon this recommendation, it would result in a dues increase; and

WHEREAS, the members of the Montana Medical Association desire to keep the contributions to the American Medical Education Foundation on a voluntary basis: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association regularly convened this 17th day of March, 1956, in Helena, go on record as opposed to such dues increase and instruct its delegate to the American Medical Association to oppose such a recommendation.

WHEREAS, the Legislative Assemblies of the State of Montana have been continuous in their consideration of the welfare and educational advancement of the young people of Montana; and

WHEREAS, this equitable consideration has prompted the members of the Legislative Assembly to give continuous support to medical and scientific studies not presently offered in the units of the University of Montana or other institutions of higher education in the Treasure State; and

WHEREAS, the 35th Legislative Assembly of Montana again affirmed this principle by its continuation of financial support to the Western Regional Educational Compact whereby deserving young men and women of Montana may secure advanced education in medicine, dentistry and veterinary science on an equal basis: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association regularly convened this 17th day of March, 1956, at its Ninth Annual Interim Session in Helena, express its grateful appreciation to the 35th Legislative Assembly of Montana for its support of the Western Regional Educational Compact.

WHEREAS, M. Shelby Jared, M.D., of Seattle, traveled a long distance to graciously address the Interim Session banquet of the Montana Medical Association; and

WHEREAS, Dr. Jared presented to us a most enlightening address on the growth of prepaid voluntary medical care plans in this Nation, and their meaning to the economics of both the physician and the patient: Therefore be it

RESOLVED, That this House of Delegates go on record as expressing its sincere thanks to Dr. Jared and those who made his appearance at our banquet possible.

WHEREAS, Montana Physicians' Service has once more extended to the Montana Medical Association its courtesies during the Interim Session; and

WHEREAS, the role which this organization has played has grown constantly in importance in the practice of our profession: Therefore be it

RESOLVED, That this House of Delegates extend its thanks to the Board of Trustees and the staff of Montana Physicians' Service for these courtesies and services.

WHEREAS, the students of Montana State University in Missoula so generously gave of their time and talent to appear at the banquet of the Ninth Annual Interim Session of the Montana Medical Association on March 16, 1956, in Helena; and

WHEREAS, these students and faculty members added much to the enjoyment of the program and extended an opportunity for a portrayal to us of one portion of the excellent work being done in our Montana schools: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association extend its thanks to Professor John Lester and the talented students who appeared before its banquet.

WHEREAS, through the professional education program of the American Cancer Society, Montana Division, Gertrude L. Pease, M.D., of the Sections of Clinical Pathology and Biochemistry of the Mayo Clinic, Rochester, Minnesota, appeared on the scientific program of the Ninth Annual Interim Session of the Montana Medical Association: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association extend its thanks to Dr. Pease and the American Cancer Society, Montana Division, for this participation.

WHEREAS, the Lewis and Clark Medical Society, its Committee on Arrangements and the Woman's Auxiliary to the Lewis and Clark Medical Society have from year to year acted as host and hostesses to members of the Montana Medical Association at its interim session; and

WHEREAS, they have graciously contributed their time, talent and effort to make this meeting extremely enjoyable: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association express its grateful appreciation to those committees of the component society and of the auxiliary.

WHEREAS, for the second consecutive year, the Veterans Administraiton Center facilities at Fort Harrison have been generously made available for the scientific sessions of the Interim Session of the Montana Medical Association; and

WHEREAS, these facilities have added immeasurably to the assemblies through which the physicians and surgeons of Montana exchange information of a scientific nature beneficial to the profession and thereby, the people of Montana: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association, convened the 17th day of March, 1956, in Helena, extend its sincere appreciation and thanks to Orville J. Andersen, M.D., Chief of Medical Services, and Mr. Claude Meredith, Center Manager, and their staffs for the courtesies accorded this Association.

WHEREAS, the Program Committee labors incessantly throughout the year to gather speakers for the scientific meetings of the Interim Session; and

WHEREAS, it has successfully produced scientific programs of interest for medical advancement, and

WHEREAS, the Program Committee has suffered many disappointments but always overcoming the obstacles: Therefore be it

RESOLVED, That a special expression of thanks be extended to Deane C. Epler, M.D., Chairman, the members of his committee, and the participating physicians and surgeons for the successful completion of an excellent program.

WHEREAS, the Helena Independent Record and radio stations KCAP and KXLJ of Helena have contributed much to the successful dissemination of information resulting from the scientific and business meetings of the Montana Medical Association at its Interim Sessions; and

WHEREAS, these media have cooperated extensively and with good grace; and

WHEREAS, the Montana Medical Association is always willing to cooperate to the fullest extent with the press and radio in information on medical subjects and is grateful for its close

association with the press and radio: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association express its appreciation to the press and radio for their services and cooperation.

WHEREAS, the Placer Hotel, the city officials and the citizens of Helena have extended themselves each spring to make the Interim Sessions of the Montana Medical Association successful; and

WHEREAS, this cooperation has made our 1956 session again most enjoyable: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association express its sincere thanks for these successful efforts and courtesies.

Dr. Gold moved that this portion of the report of Reference Committee C and the above resolutions be adopted. This motion was seconded and carried.

The following resolution proposed by H. M. Clemmons, M.D., delegate from Silver Bow County Medical Society, has been carefully studied by your Reference Committee which recommends its adoption.

WHEREAS, carefully controlled studies have demonstrated that flouridation of water supplies has been definitely beneficial in the reduction of dental caries in the younger age group; and

WHEREAS, the Council on Pharmacy and Chemistry of the A.M.A. has reported that flouride is non-toxic in community water supplies up to one part per million; and

WHEREAS, the addition of fluoride to community water supplies seems to have merit; and

WHEREAS, the House of Delegates of the American Medical Association has endorsed the principle of fluoridation of community water supplies: Therefore be it

RESOLVED, That the House of Delegates of the Montana Medical Association at its Ninth Interim Session endorse the principle of flouridation of community water supplies in Montana.

Dr. Gold moved that this portion of the report of the Reference Committee and the above resolution be adopted. This motion was seconded and carried.

Your Reference Committee reviewed with interest the report of the special committee to study M.P.S. which was appointed by President Setzer during February. It is the suggestion of your Reference Committee that the recommendation of this special committee to defer any action by the House of Delegates which would affect the present operation of Montana Physicians' Service be received without action by this House. Your Reference Committee suggests further that this special committee be instructed by the House to complete an objective study of Montana Physicians' Service and that it serve basically as a fact finding committee to report at the September meeting of this House.

Dr. Gold moved that this portion of the report of the Reference Committee be adopted. This motion was seconded and carried.

Your Reference Committee has carefully reviewed the recommendation of the Polio Advisory Committee which was re-referred to this Reference Committee to consider in conjunction with a resolution on the same subject. It is the suggestion of your Reference Committee that the recommendation of the Polio Advisory Committee that the polio vaccine program now in operation continue essentially as it is with vaccine distributed in approximately equal amounts between commercial channels and federally financed programs be disapproved and that instead this House of Delegates affirm the policy proposed by the House of Delegates of the American Medical Association last December. This policy, adopted by the A.M.A. House, recommends that as soon as practicable further purchase and distribution of Salk polio vaccine be carried on through the presently available commercial avenues used for other immunizing agencies and that all vaccines, once proven, should enter the usual channels of distribution.

Dr. Gold moved that this portion of the report of the Reference Committee be adopted. This motion was seconded and carried.

Your Reference Committee studied with interest and care the resolution about the distribution of polio vaccine presented by V. D. Standish, M.D. Your Reference Committee is of the opinion that commercial vaccine should be administered by the physician to those patients who are able to pay for it and that the federally purchased vaccine should be administered by the physician only to those patients who are unable to pay for it. Your Reference Committee, therefore, has amended somewhat the original resolution presented by Dr. Standish so that the administration of polio vaccine may be made at the discretion of the physician and so that the resolution, in effect, is a suggestion and policy proposed by this House. Your Reference Committee recommends the adoption of the amended resolution, which is as follows:

WHEREAS, the Congress of the United States has seen fit to appropriate tax funds to purchase and distribute poliomyelitis vaccine for the general public; and

WHEREAS, the practice has been to distribute this vaccine to private physicians for use in their offices with the understanding that a charge would be made for the administration and not for the vaccine itself; and

WHEREAS, the fees charged for this service do not appear to vary greatly whether the material administered is tax-purchased or procured through normal channels; it becomes evident that such a program amounts to nothing more than a subsidy to the medical profession; and

WHEREAS, men of integrity cannot be opposed to a principle in its broad and general applications and at the same time approve of an action based on that same principle when such approval becomes convenient or profitable: Therefore be it

RESOLVED, That the members of this Association are of the opinion that when such a material is given and a fee charged, as to private patients, it should come through normal commercial channels, and that only in those cases where the patient is unable to pay should the free material be used; and be it

RESOLVED further, That in such needy cases where free vaccine is administered there should be no charge made for any service connected with its administration.

Dr. Gold moved that this portion of the report of the Reference Committee and the above resolution be adopted. This motion was seconded and carried.

Dr. Gold then moved the adoption of the report of Reference Committee C as a whole. This motion was seconded and carried.

Following the adoption of these motions, H. C. Scharnweber, M.D., a delegate from the Northeastern Montana Medical Society, reminded the delegates that the United States Congress had recently approved legislation to finance purchase of additional polio vaccine and that to the best of his knowledge, the American Medical Association neither protested nor supported the additional appropriation of federal funds to continue this program. It was moved by Dr. Scharnweber, and seconded, that the House of Delegates of the Montana Medical Association express its displeasure to the Board of Trustees of the American Medical Association for its failure to advise Congress of the dangers of such a federally financed program. Following some discussion of this motion, A. W. Axley, M.D., a delegate from the Hill County Medical Society, moved that the motion be amended to

include the statement that, in the opinion of this House, as much polio vaccine as possible should be distributed through ordinary commercial channels. This amendment to the motion was seconded and upon vote, carried. The original motion was then voted upon and carried.

H. M. Clemmons, M.D., presented a resolution for the consideration of the House of Delegates which reprimanded the present legal counsel of this Association for his activities in the current controversy about the flouridation of the Helena water supply. Following some discussion of this proposed resolution, during which Secretary Vye read a letter addressed to the Association from our legal counsel reviewing his opinions and activities in the current controversy, the motion of Dr. Clemmons to adopt the proposed resolution was seconded and carried.

There being no further business, the House of Delegates recessed at 2:15 p.m. to reconvene following the meeting of the Administrative Body of Montana Physicians' Service.

The House of Delegates reconvened at 4:20 p.m., but since there was no further business to consider as a result of the meeting of the Administrative Body of M.P.S., the House adjourned, sine die at 4:22 p.m.

The following delegates and alternates attended these sessions of the House of Delegates:

Cascade County Medical Society—A. K. Atkinson, M.D.; F. H. Crago, M.D.; Harold W. Fuller, M.D.; F. D. Hurd, M.D.; John A. Layne, M.D.; Charles F. Little, M.D.; Frank M. Petkevich, M.D.; T. C. Power, M.D.; Wyman J. Roberts, M.D.; Dora V. H. Walker, M.D.; Thomas F. Walker, M.D.; John C. Wolgamot, M.D.

Fergus County Medical Society—Edward M. Gans, M.D.; Paul J. Gans, M.D.; Joseph P. Orley, M.D.

Flathead County Medical Society—Eaner P. Higgins, M.D.; Woodrow Nelson, M.D.; G. B. Wright, M.D.

Gallatin County Medical Society—Deane C. Epler, M.D.; D. D. Parke, M.D.; Frank J. Pickett, M.D.

Hill County Medical Society—A. W. Axley, M.D.; Robert H. Leeds, M.D.

Lewis and Clark Medical Society—William F. Cashmore, M.D.; Raymond O. Lewis, M.D.; Amos R. Little, M.D.; Philip D. Pallister, M.D.; Donald O. Schultz, M.D.

Mount Powell Medical Society—George M. Donich, M.D.; Harold F. Hagan, M.D.; George E. Trobough, M.D.

North Central Montana Medical Society—George D. Waller, M.D.; R. K. West, M.D.

Northeastern Montana Medical Society—H. C. Scharnweber, M.D.

Park-Sweetgrass Medical Society—W. E. Harris, M.D.; V. D. Standish, M.D.

Silver Bow County Medical Society—William A. Burke, M.D.; Harvey L. Casebeer, M.D.; H. M. Clemmons, M.D.; M. A. Gold, M.D.; Harold W. Gregg, M.D.; John A. Newman, M.D.; N. Conwell Rosston, M.D.; M. E. Tuchscherer, M.D.; V. A. Yaholkovsky, M.D.

Southeastern Montana Medical Society—James K. Cope, M.D.; John E. Low, M.D.; J. S. Pennepacker, M.D.; S. C. Pratt, M.D.; William A. Treat, M.D.

Western Montana Medical Society—L. W. Brewer, M.D.; E. J. Drouillard, M.D.; John F. Fulton, M.D.; A. R. Kintner, M.D.; L. E. Kuffel, M.D.; C. R. Svore, M.D.; Park W. Willis, Jr., M.D.

Yellowstone Valley Medical Society—Perry M. Berg, M.D.; Walter H. Hagen, M.D.; F. S. Marks, M.D.; James D. Morrison, M.D.

Obituaries

W. H. BLAKEMORE

William Harvey Blakemore, M.D., Baker, Montana, died May 8, 1956. Dr. Blakemore was a graduate of Ensworth Medical College, 1910. Following his graduation, he practiced medicine at Atlanta, Nebraska, and Sheridan, Missouri, for several years. About 1918 he moved to southeastern Montana and, in 1938, began the general practice of medicine in Baker.

Dr. Blakemore was a member of this Association and the American Medical Association.

W. F. COGSWELL

William Forlong Cogswell, M.D., died in Helena on May 26, 1956. Dr. Cogswell was a graduate of Dalhousie University Faculty of Medicine, 1894. He moved to Montana soon after graduation and practiced at both Stockett and Wilsall.

In 1908 he moved to Livingston to become the County Health Officer of Park County. Thereafter he became prominent in the field of public health and was a pioneer in the research on spotted fever. He was appointed Executive Officer of the Montana State Board of Health in 1912 and continued to hold this position until his retirement in 1946.

New Mexico Changes Editors

The Council of the New Mexico Medical Society announces the appointment of Aaron Margulis, M.D., of Santa Fe, as its State Scientific Editor and member of the Rocky Mountain Medical Journal's Editorial Board, effective with this issue of the Journal, succeeding Carl Gellenthien, M.D., of Valmora, who is retiring from the editorship after almost twelve years of continuous service. Mr. Ralph R. Marshall, Executive Secretary of the Society, will continue as Associate Editor for New Mexico.

With this announcement goes the deep thanks and appreciation of the Council to Dr. Gallenthien for his long service, not only in the Journal editorship, but in almost every other field of New Mexico Medical Society activity, including many years as a member of the Council and the unique distinction of having served two years as President of his state society.

In Dr. Margulis the Council is convinced that a worthy successor has been selected who will add further to the regional and national recognition already accorded the Rocky Mountain Medical Journal.

The Book Corner

New Books Received

New books received are acknowledged in this section. From these, selections will be made for reviews in the interests of the readers. Books here listed will be available for lending from the Denver Meaical Library soon after publication.

The Rochester Regional Hospital Council. By Leonard S Rosenfield and Henry B. Makover. Boston, Harvard University Press for Commonwealth Fund, 1956. Price: $3.50.

Hunterdon Medical Center: By Ray E. Trussell. Boston, Harvard University Press for Commonwealth Fund, 1956. Price: $3.75.

Campbell's Operative Orthopaedics: By J. S. Speed and R. A Knight. 3rd edition, 2 volumes. St. Louis, C. V. Mosby Co., 1956. Price: $40.00.

The Management of Menstrual Disorders: By C. Frederic Fluhmann. Philadelphia, W. B. Saunders Co., 1956. Price: $8.50.

The Office Assistant: By Portia M. Frederick. and Carol Towner. Philadelphia, W. B. Saunders Co., 1956. Price: $4.75.

Book Reviews

Electrocardiography; Fundamental and Clinical Application: By Louis Wolff, M.D. 2nd ed. Philadelphia, W. B. Saunders Co., 1956. Price: $7.00.

This second edition of a very good textbook on electrocardiography carries out the original format with those revisions necessary for a developing science. Among other revisions, the whole chapter on myocardial infarction has been rewritten and a new section on the arrhythmias has been added. The principles of vectorcariography have been interwoven with the text and its importance to the cardiologist emphasized in those conditions where it is most helpful in differential diagnosis.

With the increasing use of the electrocardiograph by more and more segments of the profession, electrocardiography is becoming a useful tool in the hands of an ever increasing number of physicians, making the need for this type of book ever more important.

While the clear and concise explanation of the basic principles are especially useful to students, seasoned electrocardiogram readers could also benefit by a review of the book from time to time. There is an obligation inherent in electrocardiographic readings, namely, not to read into the tracings abnormalities which are not present. A thorough understanding of the basic principles lets the doctor find the common patterns described in the second part of the book almost self-explanatory. The book covers not only fundamentals, but also the clinical application of electrocardiography.

MAURICE KATZMAN, M.D.

Ion Exchange and Absorption Agents in Medicine: By Gustav J. Martin, Sc.D. Boston and Toronto, Little, Brown & Company. Price: $7.50.

For many years Dr. Martin has been engaged in the investigation of ion exchange resins for

medical use. In this book he relates his extensive knowledge in the chemistry and clinical applications of these agents. In the first four chapters he deals with the basic chemical reaction involved in the use of ion exchange materials. Chapters Five, Six and Seven discuss the clinical aspect of the use of anions and cations in the treatment of various diseases. He devoted fifty-four pages to the treatment of anion exchange resins in peptic ulcers. It should be pointed out that this has not gained widespread acceptance.

The bibliography follows each chapter and is excellent. The index is good. This is certainly an authoritative book on this important subject and will be widely used as a reference book for those interested in this growing field of medicine.

ROBERT E. HAYES, M.D.

The Truth About Cancer: By Charles S. Cameron, M.D., Medical and Scientific Director, American Cancer Society. Englewood Cliffs, New Jersey, Prentice-Hall, Inc., 1956. Price: $4.95.

This book is written for the education of the medical profession. The author deals lucidly with the complex subject of cancer. In a pleasing and tactful manner all facets of the problem of cancer are discussed and the most common sites of cancer are described. He has adhered to the modern concepts of cancer diagnosis, treatment and prognosis.

This is a book which should be read by all lay persons who wish to be well informed. Physicians will wish to familiarize themselves with the contents. This book is a valuable contribution to the education of the public.

MARTIN E. BISCHOFF, M.D.

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An egg white whipped into fruit juice makes a frothy flip. Or you might suggest gelatin instead.

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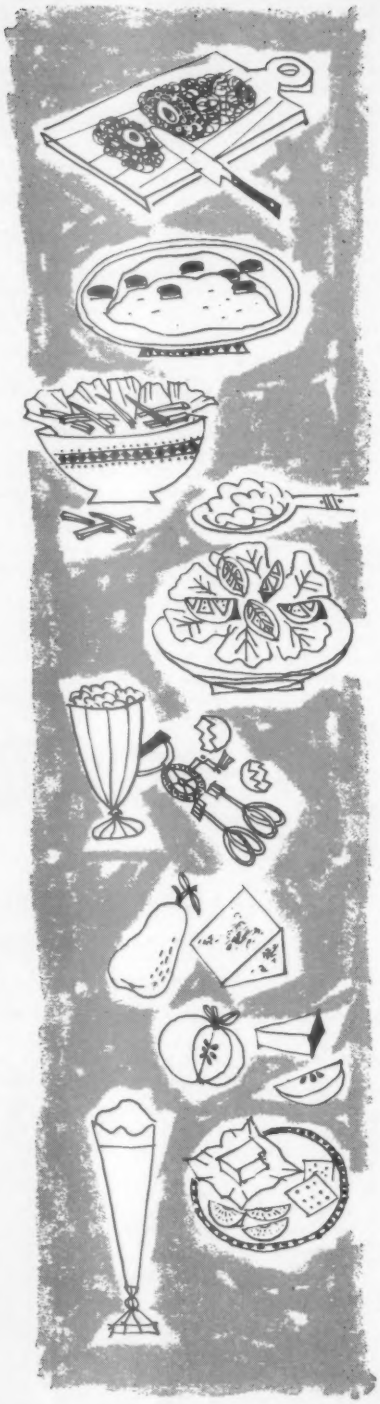

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WANTED, E.E.N.T. Specialist and Internist. Board eligible or certified; equal partnership in progressive group, in Rocky Mountain Area. Box 96, Rocky Mountain Medical Journal, Denver 2.

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GENERAL PRACTITIONER wanted at Ouray, Colorado, beginning August 1. Company affiliation. Contact Dr. Robert F. Bell, 4200 East 9th Avenue, Denver, or call DUdley 8-4511, Extension 342.

SURGEON, age 33, desires to locate in Colorado. Naval service terminates in November. Completed first part of Surgical Boards. Educational background and qualifications sent upon request. Box 102, Rocky Mountain Medical Journal, 835 Republic Building, Denver 2.

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THE COLORADO STATE MEDICAL SOCIETY

NEXT ANNUAL SESSION: SEPTEMBER 5-8, 1956; STANLEY HOTEL, ESTES PARK

OFFICERS, 1955-1956

Terms of Officers and Committeemen expire at the Annual Session in the year indicated. Where no year is indicated the term is for one year only and expires at the 1956 Annual Session.

President: Robert T. Porter, Greeley.

President-Elect: George R. Buck, Denver.

Vice President: Leo W. Lloyd, Durango.

Constitutional Secretary (three years): James M. Perkins, Denver, 1957.

Treasurer (three years): William C. Service, Colorado Springs, 1956.

Additional Trustees (three years): C. Walter Metz, Denver, 1956; Lawrence D. Buchanan, Wray, 1957; Thomas K. Mahan, Grand Junction, 1958; Terry J. Gromer, Denver, 1958.

(The above nine officers compose the Board of Trustees of which Dr. Porter is Chairman and Dr. Lloyd is Vice Chairman for the 1955-1956 year.)

Board of Councilors (three years): District No. 1: Osgoode S. Philpott, Denver, 1957; District No. 2: Roger G. Howlett, Golden, 1956; District No. 3: Harry C. Bryan, Colorado Springs, 1958; District No. 4: Paul R. Hildebrand, Brush, 1957; District No. 5: John D. Gillaspie, Boulder, 1957, Vice Chairman; District No. 6: Harvey M. Tupper, Grand Junction, 1958; District No. 7: Charles L. Mason, Durango, 1958; District No. 8: Herman W. Roth, Chairman, Monte Vista, 1956; District No. 9: Scott A. Gale, Pueblo, 1956.

Board of Supervisors (two years): William N. Baker, Chairman, Pueblo, 1957; Duane F. Hartshorn, Vice Chairman, Ft. Collins, 1957; Sam W. Downing, Secretary, Denver, 1956; J. Alan Shand, La Junta, 1956; George G. Balderston, Montrose, 1956; Lester L. Williams, Colorado Springs, 1956; Robert A. Hoover, Salida, 1958; Harold E. Haymond, Greeley, 1956; Lawrence W. Holden, Boulder, 1957; Robert C. Lewis, Jr., Glenwood Springs, 1957; Kenneth H. Beebe, Sterling, 1957; James S. Orr, Fruita, 1957.

Delegates to American Medical Association (two calendar years): Kenneth C. Sawyer, Denver, 1956; (Alternate, Irvin E. Hendryson, Denver, 1956); E. H. Munro, Grand Junction, 1957; (Alternate, Harlan E. McClure, Lamar, 1957).

Foundation Advocate: Walter W. King, Denver.

House of Delegates: Speaker, William B. Condon, Denver; Vice Speaker, Carl W. Swarts, Pueblo.

Executive Office Staff: Mr. Harvey T. Sethman, Executive Secretary; Mrs. Geraldine A. Blackburn, Executive Assistant; Mr. John W. Pompelli, Executive Assistant; 835 Republic Building, Denver 2, Colo.; Telephone AComa 2-0547.

General Counsel: Mr. J. Peter Nordlund, Attorney-at-Law, Denver.

MONTANA MEDICAL ASSOCIATION

NEXT ANNUAL SESSION: SEPTEMBER 13-15; GREAT FALLS.

OFFICERS, 1955-1956

Terms of Officers and Committees expire at the Annual Session in the year indicated. Where no year is indicated, the term is for one year only and expires at the 1956 Annual Session.

President: George W. Setser, Malta.

President-Elect: Edward S. Murphy, Missoula.

Vice President: John A. Layne, Great Falls.

Secretary-Treasurer: Theodore R. Vye, Billings.

Assistant Secretary-Treasurer: Park W. Willis, Jr., Hamilton.

Executive Secretary: Mr. L. R. Hegland, P. O. Box 1692, Office Telephone, 9-2585, Billings.

Delegate to the American Medical Association: Raymond F. Peterson, Butte.

Alternate Delegate to the American Medical Association: Paul J. Gans, Lewiston.

NEW MEXICO MEDICAL SOCIETY

75th ANNIVERSARY MEETING: MAY 15, 16, 17, 1957; SANTA FE

OFFICERS, 1956-1957

Terms of officers expire at the Annual Session in the year indicated. Where no year or term is indicated, the term is for one year only and expires at the 1957 Annual Session.

President: Stuart W. Adler, Albuquerque.

President-Elect: Samuel R. Ziegler, Espanola.

Vice President: James C. Sedgwick, Las Cruces.

Secretary-Treasurer: Lewis M. Overton, Albuquerque.

Executive Secretary: Mr. Ralph R. Marshall, 223-24 First National Bank Building, Albuquerque; telephone 2-2102.

Immediate Past President: Earl L. Malone, Roswell.

Councilors (three years): W. E. Badger, Hobbs, 1957; W. D. Dabbs, Clovis, 1957; W. O. Connor, Jr., Albuquerque, 1958; L. L. Daviet, Las Cruces, 1958; Aaron Margulis, Santa Fe, 1959; Junius A. Evans, Las Vegas, 1959.

Delegate to American Medical Association (two years): H. L. January, Albuquerque, 1958; Alternate: Earl L. Malone, Roswell, 1958.

Board of Supervisors: A. J. Jenson, Hobbs, Chairman, 1957; W. J. Hossley, Deming, Secretary, 1957; Milton Floersheim, Jr., Raton, 1957; George W. Prothro, Clovis, 1957; A. D. Maddox, Las Cruces, 1958; G. A. Slusser, Artesia, 1958; Louis Levin, Belen, 1958; Jack Dillahunt, Albuquerque, 1958.

New Mexico Physicians Service: H. M. Mortimer, Las Vegas, 1957; H. L. January, Albuquerque, 1957; Fred Hanold, Albuquerque, 1957; L. L. Daviet, Las Cruces, 1957; O. C. Taylor, Jr., Artesia, 1957; C. S. Stone Hobbs, 1957; R. P. Beaudette, Raton, 1958; R. V. Seligman, Albuquerque, 1958; Wendell Peacock, Farmington, 1958; Omar Legant, Albuquerque, 1958; Allen Haynes, Clovis, 1959; W. L. Minton, Lovington, 1959; J. P. Turner, Carrizoso, 1959; U. S. Marshall, Roswell, 1959; J. W. Hillsman, Carlsbad, 1959; Executive Director, Mr. L. J. LeGrave, 212 Insurance Building, Albuquerque, Phone 3-3188.

THE UTAH STATE MEDICAL ASSOCIATION

ANNUAL MEETING: SEPTEMBER 5-8; HOTEL UTAH, SALT LAKE CITY

OFFICERS, 1955-1956

President: R. O. Porter, Logan.

President-Elect: James E. Davis, Salt Lake.

Past-President: Charles Ruggeri, Jr., Salt Lake.

Honorary President: John Z. Brown, Sr., Salt Lake.

Secretary: Donald M. Moore, Ogden.

Executive Secretary: Mr. Harold Bowman, Salt Lake.

Treasurer: Alan P. Macfarlane, Salt Lake.

Councilor, Box Elder Medical Society: James H. Rasmussen, Brigham City.

Councilor, Cache Valley Medical Society: C. C. Randall, Logan.

Councilor, Carbon County Medical Society: L. H. Merrill, Hiawatha.

Councilor, Central Utah Medical Society: John B. Cluff, Richfield.

Councilor, Salt Lake County Medical Society: James F. Orme, Salt Lake.

Councilor, Southern Utah Medical Society: R. G. Williams, Cedar City.

Councilor, Uintah Basin Medical Society: T. R. Seager, Vernal.

Councilor, Utah County Medical Society: R. E. Jorgensen, Provo.

Councilor, Weber County Medical Society: I. Bruce McQuarrie, Ogden.

Delegate to A.M.A., 1955-1957: George M. Fister, Ogden.

Alternate Delegate to A.M.A., 1955-1956: Eliot Snow, Salt Lake.

Editor of the Utah Section of the Rocky Mountain Medical Journal, 1957: R. P. Middleton, Salt Lake.

THE WYOMING STATE MEDICAL SOCIETY

OFFICERS, 1955–1956

President: R. I. Williams, Cheyenne.

President-Elect: Joseph Hellewell, Evanston.

Vice President: H. B. Anderson, Casper.

Secretary: Benjamin Gitlitz, Thermopolis.

Treasurer: C. D. Anton, Sheridan.

Delegate to A.M.A.: W. Andrew Bunten, Cheyenne.

Alternate Delegate to A.M.A.: Albert Sudman, Green River.

Executive Secretary: Arthur R. Abbey, Cheyenne, Box 2036.

Councilors: Glen O. Beach, 1956, Casper; Joseph Whalen, 1956, Evanston; Joseph E. Hoadley, 1957, Gillette, Francis A. Barrett, 1957, Cheyenne; Wm. Hinrichs, 1958, Douglas; Loran B. Morgan, 1958, Torrington; Nels Vickland, 1956, Thermopolis; R. I. Williams, Chairman (Ex-Officio), Cheyenne; Benjamin Gitlitz, Secretary (Ex-Officio), Thermopolis.

COLORADO HOSPITAL ASSOCIATION

ANNUAL MEETING: NOVEMBER 7-8; BROADMOOR, COLORADO SPRINGS

OFFICERS, 1955–1956

President: John R. Peterson, Larimer County Hospital, Fort Collins.

President-Elect: Sister Mary Jerome, Mercy Hospital, Denver.

Vice President: Hubert Hughes, General Rose Memorial Hospital, Denver.

Treasurer: M. A. Moritz, Denver General Hospital, Denver.

Executive Secretary: Richard P. Mac Leish, Denver.

Executive Offices: 1422 Grant Street, Denver 3.

Trustees: Robert A. Pentow (1956), University of Colorado Medical Center, Denver; Roy Prangley (1956), St. Luke's Hospital, Denver; Msgr. John R. Mulroy (1956), Catholic Charities, Denver; Roy Anderson (1957), Presbyterian Hospital, Denver; Harry Clark (1957), Southwest Colorado Memorial Hospital, Cortez; Elton A. Reese (1957), Alamosa Community Hospital, Alamosa; Louis Liswood (1958), National Jewish Hospital, Denver; Charles K. Levine (1958), Beth Israel Hospital, Denver; C. F. Fielden, Jr., (1958), Memorial Hospital, Colorado Springs; Louis I. Miller, M.D. (ex-officio), Colorado Hospital Service, Denver.

Delegates: Harley E. Rice, Porter Sanitarium and Hospital, Denver; Henry H. Hill, Alternate, Weld County General Hospital, Greeley.

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